Volume II

Clinical component:

Clinical practice reports

by

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Overview

This thesis is submitted in part fulfilment of the requirements for the degree of Doctor of Clinical Psychology (ClinPsyD) at the University of Birmingham. The thesis contains the research and clinical practice work carried out over the duration of the clinical training program. All names and identifying features of participants and clients have been changed to preserve anonymity and confidentiality.

Volume I contains the research component, consisting of a literature review, an empirical paper and the public domain briefing paper. The literature review summarises the longitudinal research evidence which considers the relationship between parental psychological control and adolescent adjustment. The empirical paper explores Rational Emotive Behaviour Therapy (REBT) irrational beliefs in parents and adolescent offspring. The literature review was prepared for submission to Child Development and the empirical paper was prepared for submission to the Journal of Rational-Emotive and Cognitive-Behavior Therapy.

Volume II comprises the clinical practice component of the degree, consisting of five clinical practice reports (CPRs) submitted over the course of clinical training. CPR 1 presents a case formulation of social anxiety from cognitive and psychodynamic perspectives. CPR 2 is a service evaluation report, which investigates quality of life and therapeutic relationships in a Regional Secure Unit. CPR 3 sets out a case study of an 11-year-old boy with learning disabilities presenting with challenging behaviour at school. CPR 4 describes a single-case experimental design in which the Solihull Approach was used to intervene with a toileting problem in a 4-year-old girl. Finally, CPR 5 is an oral presentation concerning a case of an older adult referred for depression and fetishistic transvestism.
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CPR 1: Psychological Models

A psychodynamic and cognitive-behavioural formulation of the case of David
Abstract

This paper considers the case of David, a 30-year-old inpatient at a medium secure unit. David was referred to psychology for help with his social anxiety. His presenting problems are outlined in the context of his childhood experiences and events in his past. A cognitive-behavioural account of David’s anxiety is provided within the structure proposed by Beck, Rush, Shaw, and Emery (1979) and elaborated by Fennell (1989) and longitudinal and cross-sectional factors of David’s anxiety are discussed. A second account of this case is also presented. Malan’s triangles of conflict and person (Malan, 1979) are used as a framework for understanding David’s social anxiety from a psychodynamic perspective.

To maintain client confidentiality, all names and locations have been changed.
Introduction

Referral

David is a 30-year-old man who is currently an inpatient in a medium secure unit for offenders with mental health problems. He is being detained under Section 37/41 of the Mental Health Act 1983 and he has been experiencing episodes of psychosis since the age of 18. David has spent four years of his life in prison and has the last 18 months in a medium secure setting.

Due to staff shortages the multi-disciplinary team responsible for David’s detention, had not been receiving input from the psychology team for the last 18 months. Therefore, David was referred for a psychology session to assess his current mental state and to investigate the potential role of psychology in his care.

The team considers David to be progressing well through the clinic; they are looking to rehabilitate him into the community in the next 12 months. Previous psychology work has suggested that he is anxious in some social situations. In the past, when unwell, David has experienced paranoid delusional ideas. His belief that others may want to harm him on one occasion resulted in him arming himself and attacking a female stranger. Therefore, the team is concerned that if he becomes anxious when in the community he may isolate himself and become more prone to relapse and increase his risk of offending or that he may be unable to cope without a supported living arrangement.

Since his most recent admission David has engaged well with professionals; he is appropriate, pleasant and concordant with treatment. On the unit, David is often withdrawn and he avoids most of the other patients.

Background

Family and early experience

David is the middle child of three boys and his mother and father raised him until the age of 14. David reported his childhood as having been “not too bad” though he describes a difficult relationship with his father. He describes his father as “very strict” and “moody” and says that he was scared of him as a child. David reported that their father physically punished him and his older brother if they misbehaved. He says that his older brother “had it worse” but he would not say anymore on this matter. David’s parents divorced when he was 14-years-old and his father moved away from the family home. David remained in the family home with his brothers and his mother. He reports being close to his mother and says that he respects her but he describes her as “not bright” and “stupid” and says that after his father left he was able to get away with much more.
At the age of eight, David was discovered to have flat feet and was made to wear “special shoes”. David reports that he was bullied during this time and teased about his shoes. At secondary school David said he was often in trouble and described himself as “cheeky”. He occasionally truanted and would go and sniff gas with peers. He was also involved in some fights and got expelled at the age of 14. According to records, David was then sent to a school for children with behavioural problems. David’s account of his change of school is somewhat different. He says that he got sent to a different school but he describes it as a very middle class school and that being from a council estate he felt very out of place and believed that his new “flash” school mates looked down on him because of his background. David truanted frequently from this school; he was given a bus pass in order for him to attend this school but instead of going to classes he would travel around all day on the bus “in a dream world”. David left school at 15 and did not take any examinations.

Forensic and psychiatric history

At the age of 18 David began to experience symptoms of psychosis. He was “imagining things” and believed there was an “other world” where “special people” were kept and that he needed to get to this other world. At 19 he was admitted to hospital again. At the time David had paranoid delusions, thinking that others could read his mind and that the television was spying on him. He was diagnosed with drug induced psychosis having taken amphetamine in the preceding days. David discharged himself after two days.

At the age of 21 David reports believing that the police were the “key” to him getting to into his other world and so he committed a robbery in order to get arrested. He was not caught for this offence (he believed that the police ignored his offence on purpose to deny him access to the other world) and so he handed himself in. David was placed in hospital but he absconded and attempted to commit another robbery. David reports continuing psychotic symptoms at the time of this offence, however, he was judged to have planned the crime and as such was sentenced to five years in prison of which he served three.

At the age of 27 David had another episode of psychosis after he stopped taking medication and he was placed on a three year Community Rehabilitation Order for arson. The following year he was convicted of his index offence (grievous bodily harm, affray and possession of an offensive weapon). One month prior to his conviction, David had run out of medication and deteriorated quickly (“it took me like a wave”). His sleep pattern was disturbed and he thought that cars were following him and that people were staring at him. On the evening of the index offence he armed himself with a machete and told a passenger on a bus that he had “to kill a lady to get to the special world”. The passenger called the police who found David on the street a short time later. David ran into a nearby shop and struck a female customer with the machete. Fortunately the blade was blunt and the victim was not
physically hurt. David was sent to prison for this offence but his delusional thoughts continued and after a year he was transferred to his current placement at a medium secure hospital.

*Presenting Problem*

At the initial assessment David talked about his fears and anxieties regarding others; he is often concerned about what others may think of him and feels inferior. He is cross with himself for being bothered about this and feels he should be able to “rise above” it. He is also worried that others may try to attack him; “the world is full of idiots and bullies”.

Recently David had started to help out with the mobile library in the clinic but he stopped this because he felt that his peers were laughing at him. Also, David does not eat his meals in the dining room because he is fearful that he will be attacked. He begins to feel anxious about half an hour before dinnertime and goes to the dining room as early as he can to avoid the queue. He collects his dinner and takes it back to the unit to eat in his room. Four weeks ago David was transferred to a different unit and he found the move very unsettling and for several weeks spent most of his time in his room.

In summarising the information provided by David at assessment, David reported social anxiety in new places and with people he doesn’t know well and he experienced paranoid ideation in that he sees the world as a dangerous place and feels vulnerable to the harm that others may inflict upon him.

*Cognitive-Behavioural Formulation*

*Introduction*

According to Beck’s cognitive theory of emotional disorders (Beck, 1976) emotional disorders such as anxiety are maintained by a ‘thinking disorder’ in which symptoms of anxiety are accompanied by distorted thinking. At the level of consciousness this distorted thinking results in negative automatic thoughts. These rapidly occurring thoughts are interpretations of events that are based on assumptions and core beliefs, which have been shaped by experience, particularly from childhood.

In anxiety disorder the theme of the distorted thoughts is danger, so that threats are overestimated and the individuals ability to cope with that threat is underestimated (Wells, 1997). It has been suggested that these distorted thoughts stem from childhood experiences, which lead to the development of beliefs about the self as weak and vulnerable, and about others and the world as generally threatening (Butler & Matthews, 1983). A situation that is
judged as a threat is a ‘trigger’, which activates dysfunctional core beliefs resulting in automatic negative thoughts.

Although contributors to the cognitive-behavioural approach differ in their consideration of the importance of aetiological factors, David’s childhood history and his mental illness seem pertinent to his anxiety. Therefore, a longitudinal formulation examining the development of David’s anxiety and a cross-sectional formulation examining the maintenance of this disorder are presented. A diagram illustrating a cognitive-behavioural formulation of David’s case, within the structure proposed by Beck, Rush, Shaw, and Emery (1979) and elaborated by Fennell (1989), is shown in Figure 1.

**Longitudinal Formulation**

A number of childhood experiences seem relevant to David’s anxiety and might explain how dysfunctional core beliefs have developed. Although David describes his childhood as normal, he describes his father as strict man who physically punished him frequently. Despite David’s assertion that these beatings are not related to his current difficulties, it seems reasonable to suggest that the experience of being physically punished by a parent would contribute to the development of beliefs about the self as weak and vulnerable and about others as powerful and potentially dangerous. At the age of eight, David was given special shoes to wear because of his flat feet and his peers bullied him for being different. This experience is also likely to have contributed to or confirmed beliefs that the self is weak and others are dangerous.

In his early teens David began truanting from school and engaging in behaviour such as drug taking and fighting. Around this time David's father left the family home and David’s delinquent behaviour at this time could be interpreted as avoidance. The result of David’s misbehaviour was that he was expelled from school. David traces this event as a turning point in his life. He seemed to learn from this experience that it is futile to stand up for yourself or to fight back, reinforcing his earlier learned belief that others are powerful and that he is weak. The change of school took David away from his friends and placed him in an unknown environment with unknown peers. David’s description of his new school is somewhat at odds with that suggested by his files, perhaps because of his distorted thinking. David described his new school as “very middle-class” and his new peers as “flash”.

This change of school was a critical incident for David. A critical incident is an event, which ‘meshes’ with the properties of a given belief (Fennell, 1989). The new school with its seemingly superior pupils meshed with David’s view of himself as weak, activating his core beliefs: ‘I am inferior’, ‘others are superior’, and ‘the world is dangerous’. David’s automatic negative thoughts were that his new peers would not like him and that they would reject him and maybe bully him. David, therefore, sought to escape his new school and truanted.
frequently. This behaviour failed to challenge his thoughts that his new peers would reject and bully him and David learned an effective strategy for coping with his dysfunctional assumptions: social withdrawal. Eventually David was expelled again and he finished his schooling without gaining any qualifications. He had several jobs following school but all of these were manual and short-lived (“all bottom of the barrel”), typically he was unemployed. All of this furthered David’s sense of inadequacy.

From the age of 18 David began to experience psychotic episodes. It seems reasonable to suggest that his core beliefs influenced the nature of his symptoms: David felt there was a special world to which he was being denied access and that others were conspiring against him. His subsequent experiences of prison activated his core beliefs and triggered further psychotic episodes and social withdrawal. In particular, David’s time in prison seemed to reinforce his core belief that others are dangerous and his automatic negative thoughts revolved around the idea that others wished to attack him. Although David did not regard his fellow inmates as superior to him (“they’re all idiots and bullies”) he felt that his incarceration identified him with this group and, therefore, made him inferior in the eyes of wider society. In addition, the fact that he has a mental illness further reinforces David’s view of himself as different and inferior.

Cross-sectional Formulation

A consideration of David’s childhood and adult experiences informs our understanding of how his social anxiety came about. The cognitive-behavioural model, however, also requires a consideration of why and how David’s difficulties are maintained. According to this model, critical incidents activate core beliefs, which lead to an increase in what Beck et al. (1979) termed negative automatic thoughts.

For David, an event that is judged as a threat is a trigger. Situations that are threatening are those where he is around unfamiliar peers. When David is in a situation where unknown peers are present, his automatic negative thoughts centre on ideas that he might be attacked and that others are looking at him and judging him to be inferior. These thoughts result in David becoming hypervigilant to the possibility of attack because he sees himself as weak and inferior; his thought processes become biased and selectively attend to threat related material. For example, when David began to help on the mobile library he was required to take books to unknown peers. Having to interact with unknown peers activated his automatic negative thoughts (e.g., ‘other people are looking at me’) and so when he heard peers laughing, David assumed they were laughing at him. This is what Beck et al., refers to as a ‘thinking error’. In this case the error is ‘personalising’ in that an external event has been related to the self even though there is no evidence to suggest that his peers were laughing at him.
Attending the dining room for evening meals is another trigger for David. Again, exposed to unfamiliar peers his automatic negative thoughts are activated. David particularly dislikes having to queue for long periods. Whilst queuing, David’s is hypervigilant to any potential threat and his most frequent automatic negative thought is ‘someone is going to attack me’. In this situation David makes several thinking errors. He is ‘overgeneralising’ because in 18 months he has been threatened by a peer once, he is ‘catastrophising’ by thinking about the worst possible outcome and overestimating the likelihood of that occurring, and he is ‘mind reading’ because he is assuming that people are judging him. In addition, David ‘minimises’ positive experiences he has had in the dining room so that when peers have made friendly gestures towards him he ignores these incidents and discounts their significance.

This distorted processing of stimuli in the environment serves to maintain David’s anxiety. Negative information which supports dysfunctional core beliefs and assumptions is attended to whilst information which challenges these is ignored or discounted. David’s autonomic anxiety, however, is also maintained by his behaviour. When he perceives a threat David’s body initiates physiological changes to enable him to fight the threat or to flee the situation. Because his beliefs revolve around the notion that he is weak and inferior his overwhelming desire is to escape from threat situations. David gave up the mobile library round after one day and, whilst the dining room can not be avoided entirely, he takes steps to ensure that he is in and out as quickly as possible; he never remains in the dining room to eat but takes his food back to his room on the unit. Once David has escaped an anxiety-provoking situation his physiological symptoms of anxiety, which for him are “butterflies in the stomach”, subside. This removal of an unpleasant physical sensation is negative reinforcement and rewards David for leaving the challenging situation. By escaping these situations, however, he also reinforces the idea that he cannot cope with such situations and that his ‘bottom line’, I’m inferior, is true.

Therefore, as illustrated by the diagram in Figure 1, a vicious cycle has been established. David’s thoughts, feelings and behaviours can be seen as inter-related (Greenberger & Padesky, 1995), with each element feeding into the other.

Summary

Core beliefs and assumptions about the self, others, and the world derive from experience and are reasonably stable constructs which the self uses to screen, organise and process information (Beck et al., 1979). Thus, David developed core beliefs, which made sense of his experiences and developed assumptions and rules for living that reflected these underlying beliefs. This is an adaptive ability and occurs in normal functioning, however, David’s experiences have led him to develop dysfunctional core beliefs and assumptions,
which revolve around the notion that he is inferior. His past experience with peers means that encounters with unknown peers act as triggers. These triggers set off a pattern of maladaptive thinking and avoidance behaviour, which serves to reinforce and maintain the anxiety he experiences in social situations.

One strength of cognitive-behavioural formulation is that the client is encouraged to participate in the process so that the formulation is collaborative and open. The current formulation, therefore, was arrived at with input directly from David and a diagram (see Figure 1.) was shown to him. This process seemed to be empowering for David and enabled him to gain new insight into how his current difficulties might have arisen. In addition, this process enabled David to recognise the link between his thoughts and behaviour and led to a successful intervention in which he was able to challenge his dysfunctional thoughts and change his behaviour to break the maintenance cycle.

David’s acceptance of the formulation and this model makes it difficult to criticise this approach with this client. One potential weakness, however, is that the cognitive-behavioural approach does not consider the impact of David’s early life experiences beyond their involvement in the development of dysfunctional core beliefs and assumptions. In addition, it could be hypothesised that David’s acceptance of this approach is related to this; he is extremely reluctant to discuss his early experiences in any detail and does not consider them relevant to his current problems. The improvement in David’s social anxiety (e.g. attending meals in the dining room), however, would suggest that this approach has been useful for David and this positive result might encourage him to engage with therapy again in the future if there are indeed issues from his past that were not addressed in this formulation.
Figure 1. A Cognitive-Behavioural Formulation of David’s Case

Early experience
- Punitive father
- Bullied at primary school
- Moved to a new school – new peers from a middle-class background

Critical Incidents
- Unemployment
- Development of mental illness
- Prison sentence
- Drug use

Core beliefs and assumptions
- I am inferior - I should be better than I am
- Other people are superior - The world is dangerous for the weak

“Bottom line”
- I’m inferior

Trigger
- e.g. Evening meal times

(Maintenance cycle)

Activation of “bottom line”

Emotions
- Anxiety
- Depression

Negative automatic thoughts
- Someone is going to attack me
- Other people are looking at me

Behaviour
- Withdraw
- Isolate self

Confirmation of “bottom line”
Psychodynamic Formulation

Introduction

There are a number of theoretical models, which sit under the umbrella term of psychodynamic; however, there are common features among these models. These include the importance of the unconscious and unconscious processes, which strive to manage psychological and emotional pain. Another key feature is early childhood experience, which is considered as fundamental in forming our ‘internal’ world, and, therefore, to understand difficulties in the present a psychodynamic approach looks to development and the past. Psychodynamic formulation also has a “tripartite structure” (Hinshelwood, 1995, p.157), which reflects the essentially triangular nature of relationships. This structure was first proposed by Menninger (1958) and has been expanded by Malan (1979).

Malan (1979) suggests a form of psychodynamic formulation, which is a “universal technique” and compatible with a range of psychodynamic models. This approach will be used in the current formulation and a diagram illustrating a psychodynamic formulation of David’s case, using the Malan (1979) triangles is shown in Figure 2. The approach takes a dynamic perspective and conceptualises the interactive forces of mental life as they act to avoid psychic pain, which results from inner conflict between aspects of the self (Leiper, 2006).

The technique devised by Malan (1979) considers two triangles: the triangle of conflict and the triangle of person. The triangle of conflict considers intra-psychic dynamics between an individual’s defence, anxiety, and hidden feelings or impulses. Defence is the means by which the individual protects themselves from their anxiety and both the defence and the anxiety may be in conscious awareness. “Lying underneath” the anxiety and the defence is the hidden feeling or impulse (Malan, 1979, p.80), this feeling or impulse is hidden because it is unconscious.

The triangle of person describes the development of intra-psychic processes from an interpersonal context and considers this in the here and now in the relationship with the assessor (transference), in current or recent past relationships (other) and early infantile relationships from the distant past (parent). Although the triangles are represented separately in Figure 2, the dynamics of the triangle of conflict are present in all interpersonal contexts. The triangle of conflict, therefore, can be thought of as being superimposed on each apex of the triangle of person. Hinshelwood (1995) suggests that in formulation one should look for a common theme among the relationships in each apex of the triangle of person. This points to the core object relationship which “points directly to a core of pain” (Hinshelwood, 1995, p.162).
**Triangle of Conflict**

It is suggested that David’s defences serve to protect David from his hidden feeling of anger towards others for his unmet relational needs and his repressed need for close relations with others. These feelings have been defended against because David fears rejection and physical attack from others (his anxiety). David’s most frequently employed defences are avoidance and, when he cannot avoid social interaction, to present himself as submissive and acquiescent. David also seems to repress his feelings regarding his father; he refuses to talk in any detail about their relationship as he feels it is not relevant to his life. It could be hypothesised that in the past these defences have not been sufficient to protect David from his hidden feelings and, therefore, a “second line of defence” (Leiper, 2006) in the form of delusional beliefs has manifested.

The word “special” keeps occurring in David’s story and is perhaps a theme. On the one hand David wants to be special in the sense of being loved and valued but he often seemed to find himself as being special in the sense of being different and isolated. As the middle child of the family he may have struggled in the competition for attention; he recalls that his father did not bully his younger brother but that his older brother had it worse. The special shoes and the special school David was sent to did not make him loved and accepted. The content of David’s delusional beliefs perhaps reflect this hidden feeling and anxiety; he wants to be with “special people” and is longing for this specialness like a baby needing attention and containment from his mother but at the same time he is anxious that he will be rejected.

David’s defences are maladaptive and are the bases of his presenting difficulties. The triangle of conflict is played out in all of David’s relationships. Where possible David avoids social interaction since he fears that his peers will reject him or physically attack him. In relationships with staff and in the transference relationship, David was unable to avoid interaction and so he presented as acquiescent and subservient and idealised relationships to try and gain approval and ward off rejection. These defences could be seen as relatively successful in that David is not currently exhibiting any psychotic defence mechanisms. However, his current defences are preventing him from seeking meaning interpersonal relationships.

**Triangle of Person**

David’s current difficulties appear to stem from relational patterns that began when he was a child. His relationship with his father was clearly difficult and having a harsh, punitive and “moody” caregiver may have resulted in David fearing judgement, learning from this relationship with his father that he may be found wanting and then be punished. As a child David would have learned certain behaviours in order to maintain safety and security in
his relationships with his parents. He may have learned to be co-operative and pleasing in order to try and avoid giving his father cause to punish him but, given that his father could be unpredictable, he may also have learned that escape was the most successful strategy to avoid judgement.

In his current and recent past relationships, therefore, it can be hypothesised that this pattern from David’s past is repeated. David as a child is likely to have felt weak and stupid in his father’s eyes and, although he is now an adult, this anxiety is continued in his relationships with staff and peers. Fearing judgement from his peers he minimises his contact with them and isolates himself from them as much as possible. He is less avoidant with staff but his presentation is very submissive and compliant and it is suggested that he is also fearful of judgement in these relations.

The core object relationship, therefore, seems to reflect David’s past experiences so that his rejecting, punitive, and judgmental father has been retained as an internal “rejecting object” (Fairburn, 1952). In relationships this internal figure is externalised and projected onto the external world so that David expects others to respond to him in a judgmental and unfriendly manner.

Considering David’s relationship with his mother, although he has generally talked about his mother in a positive way, his criticism of her as stupid might suggest that there is some hidden anger directed towards her and maybe guilt about this anger. David did not want to discuss this relationship in any detail so it is difficult to give a plausible account of this relationship. In a meeting with another professional, David’s mother expressed regret that she had not protected her son from her husband so perhaps there is hidden anger towards her from David for her failure to protect him. There may also be hidden feelings towards the mother that can be traced back to the break-up of the marriage. For example, if David had not wanted his father to leave this may have left him with feelings of abandonment and rejection, which may have resulted in anger towards his mother.

Transference and countertransference.

In the sessions with David, I often felt quite protective towards him, as he seemed very vulnerable but also very eager to please. Thus, in accordance with the pattern of relationships in the recent and distant past, David was perhaps fearful of rejection and wanting very much to be accepted. In later sessions David appeared to idealise me and often mentioned how helpful the sessions had been to him. David also made comments such as “you must think I’m stupid” and “I bet you think I’m daft”. His style and his comments seemed to be a defence against a fear of rejection and a fear of being thought of as stupid.

When David discussed his childhood he always seemed to play down the impact this may have had on him. In relation to his father’s punishment of him, this made me feel quite
angry even though David was not. In addition, when David was describing his mother in a negative way (“she’s stupid”), I felt myself recoiling. It is suggested that at these times David may have projected his anger towards his father and the guilt from his anger towards his mother onto me (projective identification).

Although David engaged well in sessions he declined the offer to continue receiving psychological input after the six sessions that had been initially agreed were ended. It could be hypothesised that further sessions would have led to a closer relationship and that this was too anxiety provoking so he defended this with avoidance. I felt quite sad and disappointed when David revealed this as I thought he had been doing well in sessions and believed he would continue to do so. It could be suggested that my feelings were a reflection of how David was feeling about the work ending, however, given that I had several external motivations for wanting the sessions to continue this is a very tentative suggestion.

Summary

Using Malan’s two triangles a psychodynamic formulation of David’s social anxiety has been presented. This formulation, however, was difficult to test because David was unwilling to talk about his past family life in great detail and to pursue psychological input beyond a short number of sessions.

Based on the information available some hypotheses have been suggested but it should be noted that some of David’s difficulties, for example his psychosis and paranoia, might be due to neurophysiological change brought about substance misuse rather than be rooted in his early relationships. Taking a psychodynamic perspective, however, David’s current difficulties might be traced back to his relationships with his parents and early experiences of being bullied.

In particular, the pattern in David’s past, current and transference relationships suggest that the core object relationship reflects David’s experiences with his father. David has internalised this rejecting object, which he then projects onto the external world so that he expects others to judge him unfavourably and maybe even physically attack him. Considering the triangle of conflict it is hypothesised that David’s hidden feelings could be anger towards his father for judging and rejecting him, and/or, towards his mother for failing to protect him from his father or for driving his father away. It is also suggested that David is repressing his desire for close interpersonal relationships.
Figure 2. A Psychodynamic Formulation of David’s Case

**Triangle of conflict**

**Defence**
- Avoidance of social situations
- Anger at self (an identification with the father)
- Delusional beliefs /psychosis
- Idealisation, acquiescent and subservient behaviour
- Repression of anger towards father and/or mother

**Anxiety**
- Fear of rejection/attack
- Fear of looking and feeling weak and stupid
- Fear that not special enough to be loved

**Hidden Feeling/Impulse**
- Anger at mother - failing to protect from father? / blamed for father leaving?
- Anger at father - physical abuse? / rejection? / abandonment?
- Need for close relationship/to have emotions contained and understood

**Triangle of person**

**Other**
- With peers, fearful and avoidant
- With staff, compliant and pleasant

**Transference**
- Eager to please
- Vulnerable
- Fear of judgement

**Past**
- Father – harsh, punitive, inconsistent, judgmental, rejecting
- Mother – warm, caring, stupid, unable to protect
References


CPR 2: Service Evaluation

Quality of Life and Therapeutic Relationships
in a Regional Secure Unit
Abstract

This study aimed to investigate quality of life (QoL) and therapeutic relationship among mentally disordered offenders at a local regional secure unit (RSU). Previous research suggests that perceived QoL is an important consideration for those with mental illness and that maintaining a satisfactory QoL is a realistic goal for service providers and an acceptable goal for service users. The quality of therapeutic relationships is also an important consideration for those with mental illness and may be central to QoL in long term service users. Forty-nine patients (58%) at the RSU consented to participate and completed two measures of QoL and a questionnaire asking about the quality of their relationships with various professionals engaged in their care. Comparing the results to an earlier evaluation at the RSU, the current findings show that perceived satisfaction with leisure, financial situation, and living situation has improved but that satisfaction in other domains (e.g., social relations) has decreased. Therapeutic relationship was found to correlate with perceived overall well-being. In particular, the quality of relationships with psychiatry and occupational therapy staff was related to global well-being.
Introduction

‘Quality of life’ (QoL) is a broad concept and there are numerous definitions. For example, the World Health Organisation defines QoL as: “an individual’s perception of their position on life in the context of the culture and value systems in which they live, and in relation to their goals, expectation, standards and concerns” (WHOQOL Group, 1994). A popular and simple definition for QoL provided by Lehman (1983) is: “the sense of well-being and satisfaction experienced by people under their current life conditions” (p.143).

Oliver, Huxley, Bridges and Mohamad (1996) identify some thirteen reasons for the measurement of QoL as it applies to mentally ill people. The Clearing House (2002), which is the national body responsible for addressing health outcomes, has suggested that it is essential to consider how an individual’s QoL may have changed since the health intervention and not simply to use symptom change as the outcome measure. One reason for this is that individuals with a severe mental illness cannot realistically be expected to regain full levels of functioning and become symptom-free. Maintaining a satisfactory QoL, however, is a realistic goal for service providers and an acceptable goal for service users (Oliver et al., 1996). QoL measures, therefore, are established as an important outcome criterion in the evaluation of mental health services.

As well as being regarded as a useful consideration for mental health services in general, QoL has been identified as an important construct for evaluating the care received by individuals with schizophrenia. Evidence has shown that improvements in QoL not only aid individual recovery and rehabilitation in schizophrenia but may also help to prevent relapse (Meltzer, 1999; Ho et al., 1998).

Much of the research investigating QoL has measured community outpatient satisfaction. By contrast, very little research has measured QoL in hospital settings. Oliver et al. (1996) suggest that one difficulty relates to the clients who are admitted to inpatient services. These clients tend to have more severe forms of psychopathology than outpatients and, therefore, may have distorted cognitive processes, which could make subjective ratings of QoL unreliable. Despite this difficulty, several authors have identified a great need for QoL assessment in hospitalised patients (e.g., Coid, 1993; van Nieuwenhuizen, Schene, & Koeter, 2002). Severely disabled patients can make important gains in social functioning and QoL when supported in specialised rehabilitation units. In patients with severe and enduring difficulty, such gains would not be detected by measures of symptom severity.

Hospitalised patients in forensic settings pose further difficulties for research in QoL. Detention in such a setting is likely to have a great impact on an individuals’ satisfaction with life. For example, patients admitted to such a setting will experience a loss of freedom and autonomy, restricted access to friends and family, and limited availability of recreational,
occupational and educational resources. In addition, individuals will share their living space with severely mentally disordered offenders some of whom will have a history of violent behaviour. The relevance of current QoL measures, which have been developed with community samples, therefore, needs to be established

Walker and Gudjonsson (2000) conducted one study, which has measured QoL in a forensic inpatient setting. These researchers compared the QoL of 58 detained mentally disordered offenders with normative data from the general psychiatric community (outpatients). They reported that there was no significant difference between these two groups for the overall score though several domains were found to be significantly worse for detained patients. These domains were living situation (including privacy, control, and independence), physical health, and physical safety.

In 2003, an investigation of subjective QoL was conducted at a medium security local regional secure unit (RSU). The survey obtained data from 55 in-patients from different units within the RSU. The units differ in level of security: secure, rehabilitation, and low secure. The investigation found that as security level increased, there were significant decreases in satisfaction regarding the other people they lived with, privacy, and overall QoL.

The 2003 investigation compared the QoL ratings from the RSU with previously reported samples of general psychiatric outpatients (Oliver et al., 1996), medium secure unit (MSU) patients (Walker & Gudjonsson, 2000), and high-security discharge patients (Walker & Gudjonsson, 2000). Compared with the other medium security data, patients in this study were less satisfied with opportunities to engage in religious/spiritual practices, more satisfied with their legal understanding and more satisfied with their general safety than the MSU sample were. Compared with the general psychiatric outpatients and the high-security discharge patients, the RSU sample was less satisfied with their work opportunities, financial situation and living situation. The RSU sample was, however, more satisfied with their social relations and health than the general psychiatric outpatient group was.

In 2005 the local RSU repeated the QoL evaluation. Compared with the general psychiatric outpatients group, this sample were less satisfied with their finances and living situation but more satisfied with their family relations, social relations, health and general well-being (Gillings, 2005).

Although QoL has become a popular construct and is considered an important outcome variable in mental health care, some researchers have suggested that the quality of the therapeutic relationship or the therapeutic alliance, as subjectively assessed by the patient, is also a significant predictor of outcome in the treatment of schizophrenia but one which has been neglected (McCabe, Roder-Wanner, Hoffmann, & Preibe, 1999).

The therapeutic alliance between therapist and their clients has been described as having four elements (Gaston, 1990). First, the extent to which both therapist and client agree
on the goals to be worked towards; second, the client’s ability to work towards these goals; third, the therapist’s empathy and involvement; and fourth, the emotional connection between the therapist and client and the client’s commitment to treatment.

Frank and Gunderson (1990) investigated therapeutic alliance in 143 patients with non-chronic schizophrenia and report that patients who formed a good alliance with their therapist within the first six months of treatment were more likely to remain in psychotherapy, comply with medication and achieve better outcomes after two years (and with less medication), than patients who did not form a good relationship.

McCabe et al. (1999) investigated QoL and therapeutic relationship in first-admission and long-term schizophrenia patients. A significant relationship between QoL and therapeutic relationships was found in the long-term but not the first-admission group. In addition, the relationship between overall life satisfaction and therapeutic relationship increased from the initial assessment to the follow-up assessment eighteen months later.

McCabe et al. (1999) suggest that therapeutic relationships may become more central to QoL in long-term care situations as it becomes increasingly embedded in patient’s overall satisfaction with life. It could be hypothesised that stronger therapeutic relationship results in improved mental state, which in turn leads to improvements in perceived QoL as the distress caused by mental illness is alleviated. Alternatively, or in addition, a strong therapeutic relationship could improve QoL by providing social support or a confidante. For long-term forensic patients with schizophrenia, the strength of the relationship between professionals and patients might influence freedom, autonomy, privacy, access to leisure facilities and even who is allowed to visit them. The satisfaction of an individual with their therapeutic relationships, therefore, might influence multiple domains of QoL.

The current study was part of a larger investigation of QoL being conducted at the RSU. The main objective of the current study was to repeat the QoL evaluation at the RSU and to compare the results with data collected from the same site in 2005. Two measures of QoL were used: Lancashire Quality of Life Profile (LQOLP) and World Health Organisation Quality of Life Assessment (WHOQOL-BREF). The WHOQOL-BREF was included to investigate whether a shorter measure of QoL would be a useful tool for measuring QoL in this population. A second aim of the study was to compare the demographic variables of participants and non-participants to consider whether the sample obtained was representative of the RSU population. The third aim was to investigate patient perception of the professionals involved in their care and to explore this variable in relation to QoL.
Method

Participants

All 85 patients at the RSU were invited to participate in the study. The patients are male mentally disordered offenders being detained under the Mental Health Act (1983). 49 patients (58%) consented to participate.

Procedure

Patients at the RSU were approached by one of the investigators and asked if they would be interested in taking part in a study investigating their quality of life. Patients were given an information sheet (Appendix 1) explaining the nature of the study and were reassured that there was no obligation to participate and that they could withdraw from the study at any time. If the patient was willing to take part they were asked to provide written informed consent by signing a consent form (Appendix 2).

Each participant was asked to complete the LQOLP (Appendix 3) interview, the WHOQOL-BREF (Appendix 4), and the Therapeutic Relationships Questionnaire (TRQ; Appendix 5). Patient variables (e.g., age, and ethnicity) were obtained from RSU records.

Psychology staff administered the questionnaires. The LQOLP is designed to be administered as an interview and it was decided that the other two measures (WHOQOL-BREF and TRQ) would also be administered in this way. Previous research at the RSU has indicated that many patients have literacy problems and/or would find it difficult to complete questionnaires without assistance. The questionnaires were administered one to one in a private interview room on their unit.

Measures

LQOLP (Oliver, et al. (1996).

The LQOLP is a structured interview, which asks respondents to rate their satisfaction in nine life domains and for general well being. The life domains rated in the LQOLP are: work/education, leisure, religion, finances, living circumstances, legal and safety, family relations, social relations, and health. Satisfaction for each life domain is measured on a 7-point Likert scale with a higher score indicating greater satisfaction. Respondents are also asked to rate their overall satisfaction with life on the 7-point scale and also on a measure of global well-being (Cantril’s Ladder: Cantril, 1965). The LQOLP was developed for use with mentally ill patients in the community but it has also been used to evaluate QoL in mentally disordered offenders in secure settings (Walker & Gudjonsson, 2000; Swinton, Oliver & Carlisle, 1999). The LQOLP has been described as having good to adequate reliability and validity (see Oliver et al., 1996, pp65-83). Test-retest reliabilities for overall satisfaction with
life range from 0.49 to 0.78 and internal consistency reliabilities (Cronbach’s alpha) of the scales range from 0.84 to 0.86 (Lehman, 1996).

**WHOQOL-BREF (WHOQOL Group, 1998).**

The WHOQOL-BREF is a 26-item self-report questionnaire. It measures subjective quality of life in four domains: physical health, psychological well-being, social relations, and environment. Respondents are asked to rate their satisfaction on a 5-point Likert scale according to how they have felt in the last two weeks. Higher scores indicate higher levels of satisfaction. The WHOQOL-BREF has been described as having good psychometric properties; internal consistency reliability (Cronbach’s alpha) across a number of research centres was described as acceptable (>0.7) (Skevington, Lofty, & O’Connell, 2004). In addition the WHOQOL-BREF has been used successfully to measure QoL over time in individuals with chronic schizophrenia (van de Willige, Wiersma, Nienhuis, & Jemmer, 2005)

**TRQ (McCabe et al., 1999).**

The TRQ was based on the modified version of the Helping Alliance Scale used by McCabe et al. (1999) in their research. Three questions were used to measure therapeutic relationship with each of four professionals from Psychiatry, Psychology, Occupational Therapy (OT), and Nursing (Keyworker). All patients at the RSU have a designated professional from each of these four disciplines. The TRQ items ask about Treatment, Understanding, and Respect. For example, the questions relating to the patients relationship with their psychiatrist were:

Do you believe you are receiving the right treatment for you from your psychiatrist? Does your psychiatrist understand you and is s/he engaged in your treatment? Do you feel respected and well regarded by your psychiatrist? Each item was rated on an 11-point visual analogue scale where 0 = not at all and 10 = yes entirely; a higher score indicating a better therapeutic relationship.

**Results**

**Participant Characteristics**

The mean age of participants was 34 years. The majority of participants were Caucasian (39%; N = 19), 37% (N = 18) were Black (e.g., Black-Caribbean, Black-African), 14% (N = 7) were Asian (e.g., Pakistani, Indian), and 10% (N = 5) were from a mixed ethnic background.

At the time of the study the majority of participants were resident on an unlocked rehabilitation unit (65%; N=32); 20% (N=10) were on a secure/locked acute unit and 15% (N=7) were on an open long-term low secure unit.
The characteristics of participants were compared to the characteristics of RSU patients who declined to take part in the study. Table 1 shows the characteristics of participants, non-participants and the whole RSU population. There was no significant difference between participants and non-participants for age ($t(83) = 0.20, ns$), ethnicity ($\chi^2(2) = 0.21, ns$), or unit type (secure vs unlocked/open: $\chi^2(1) = 3.51, ns$).

Table 1. Characteristics of participants, non-participants and all RSU patients

<table>
<thead>
<tr>
<th></th>
<th>Participants</th>
<th>Non-participants</th>
<th>RSU</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 49</td>
<td>N = 36</td>
<td>N = 85</td>
</tr>
<tr>
<td>Average age (years)</td>
<td>34</td>
<td>37</td>
<td>35</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>39%</td>
<td>36%</td>
<td>38%</td>
</tr>
<tr>
<td>Black</td>
<td>37%</td>
<td>42%</td>
<td>39%</td>
</tr>
<tr>
<td>Asian</td>
<td>14%</td>
<td>17%</td>
<td>15%</td>
</tr>
<tr>
<td>Mixed</td>
<td>10%</td>
<td>5%</td>
<td>8%</td>
</tr>
<tr>
<td>Unit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute/Secure</td>
<td>20%</td>
<td>36%</td>
<td>28%</td>
</tr>
<tr>
<td>Rehab/Unlocked</td>
<td>65%</td>
<td>50%</td>
<td>59%</td>
</tr>
<tr>
<td>Long-term/Open</td>
<td>15%</td>
<td>11%</td>
<td>13%</td>
</tr>
</tbody>
</table>

Quality of Life

Scores obtained on the LQOLP by the current sample were compared with scores obtained from the RSU in 2005 (Gillings, 2005) but no significant differences were found (see Table 2).

Table 2. LQOLP means and standard deviations for current and previous samples

<table>
<thead>
<tr>
<th>Domain</th>
<th>Current sample</th>
<th>2005 sample</th>
<th>Current sample</th>
<th>2005 sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 49</td>
<td>N = 57</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Work</td>
<td>3.73</td>
<td>1.12</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Leisure</td>
<td>4.83</td>
<td>1.17</td>
<td>4.75</td>
<td>1.10</td>
</tr>
<tr>
<td>Religion</td>
<td>4.49</td>
<td>1.61</td>
<td>4.55</td>
<td>1.28</td>
</tr>
<tr>
<td>Finance</td>
<td>3.86</td>
<td>1.59</td>
<td>3.06</td>
<td>1.45</td>
</tr>
<tr>
<td>Living Situation</td>
<td>3.90</td>
<td>1.21</td>
<td>3.71</td>
<td>1.32</td>
</tr>
<tr>
<td>Legal and Safety</td>
<td>4.51</td>
<td>1.42</td>
<td>4.67</td>
<td>1.69</td>
</tr>
<tr>
<td>Family Relations</td>
<td>5.18</td>
<td>1.50</td>
<td>5.24</td>
<td>1.25</td>
</tr>
<tr>
<td>Social Relations</td>
<td>5.02</td>
<td>1.08</td>
<td>5.16</td>
<td>1.11</td>
</tr>
<tr>
<td>Health</td>
<td>4.68</td>
<td>1.28</td>
<td>4.96</td>
<td>1.25</td>
</tr>
<tr>
<td>Global Well-Being</td>
<td>4.45</td>
<td>1.60</td>
<td>4.86</td>
<td>1.47</td>
</tr>
</tbody>
</table>

$^1$Gillings (2005)

Scores obtained on the WHOQOL-BREF by the current sample were compared with scores obtained from the RSU in 2005 (Gillings, 2005) (see Table 3). The domain of Work was excluded in the previous study and can not be compared across time. No significant
difference was found between the previous sample and the current sample for WHOQOL-BREF domain scores.

Table 3. WHOQOL-BREF scores for current and 2005 sample

<table>
<thead>
<tr>
<th>Domain</th>
<th>Current sample</th>
<th>2005 sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Physical</td>
<td>66.77</td>
<td>17.53</td>
</tr>
<tr>
<td>Psychological</td>
<td>60.53</td>
<td>18.64</td>
</tr>
<tr>
<td>Social</td>
<td>50.15</td>
<td>24.17</td>
</tr>
<tr>
<td>Environment</td>
<td>58.31</td>
<td>18.03</td>
</tr>
</tbody>
</table>

Gillings (2005)

Global well-being scores from the LQOLP correlated significantly with WHOQOL-BREF scores (Physical: r = .582, p<.001; Psychological: r = .702, p<.001; Social: r = .434, p<.01; Environment: r = .650, p<.001). Significant correlation was also found between WHOQOL-BREF Social and LQOLP Social Relations (r = .410, p<.01); WHOQOL-BREF Physical and LQOLP Health (r = .440, p<.01); WHOQOL-BREF Psychological and LQOLP Leisure, Legal and Safety, Family and Social (r = .314, p<.05; r = .348, p<.05; r = .326, p<.05; r = .305, p<.01); WHOQOL-BREF Environment and LQOLP Living Situation, Legal and Safety, and Social (r = .757, p<.001; r = .666, p<.001; r = .563, p<.001).

Table 4. LQOLP means and standard deviations by type of unit

<table>
<thead>
<tr>
<th>Domain</th>
<th>Acute/Secure</th>
<th></th>
<th>Rehab/Unlocked</th>
<th></th>
<th>Long-term/Open</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 10</td>
<td>SD</td>
<td>N = 32</td>
<td>SD</td>
<td>N = 7</td>
<td>SD</td>
</tr>
<tr>
<td>Work</td>
<td>3.50</td>
<td>1.21</td>
<td>3.57</td>
<td>1.06</td>
<td>4.62</td>
<td>0.93</td>
</tr>
<tr>
<td>Leisure</td>
<td>4.58</td>
<td>0.90</td>
<td>4.70</td>
<td>1.22</td>
<td>5.67</td>
<td>0.94</td>
</tr>
<tr>
<td>Religion</td>
<td>5.06</td>
<td>1.45</td>
<td>4.33</td>
<td>1.48</td>
<td>4.10</td>
<td>2.41</td>
</tr>
<tr>
<td>Finance</td>
<td>4.00</td>
<td>1.80</td>
<td>3.75</td>
<td>1.44</td>
<td>4.14</td>
<td>2.12</td>
</tr>
<tr>
<td>Living Situation</td>
<td>4.56</td>
<td>1.14</td>
<td>3.61</td>
<td>1.15</td>
<td>4.36</td>
<td>1.27</td>
</tr>
<tr>
<td>Legal and Safety</td>
<td>4.78</td>
<td>1.28</td>
<td>4.38</td>
<td>1.49</td>
<td>4.75</td>
<td>1.44</td>
</tr>
<tr>
<td>Family Relations</td>
<td>5.30</td>
<td>1.58</td>
<td>4.98</td>
<td>1.52</td>
<td>6.00</td>
<td>1.10</td>
</tr>
<tr>
<td>Social Relations</td>
<td>4.70</td>
<td>1.16</td>
<td>4.98</td>
<td>1.05</td>
<td>5.64</td>
<td>1.03</td>
</tr>
<tr>
<td>Health</td>
<td>4.25</td>
<td>1.16</td>
<td>4.70</td>
<td>1.34</td>
<td>5.21</td>
<td>1.04</td>
</tr>
<tr>
<td>Global Well-Being</td>
<td>4.15</td>
<td>1.73</td>
<td>4.23</td>
<td>1.55</td>
<td>5.86</td>
<td>0.90</td>
</tr>
</tbody>
</table>

LQOLP scores varied significantly by type of unit for the domains of work (F(2) = 3.44, p = .043) and living situation (F(2) = 3.21, p = .05). Specifically, participants on long-term open units reported greater satisfaction with their work opportunities than those on acute secure units did (Dunnett T3 = 1.45, p = .008) and participants on acute secure units reported greater satisfaction with their living situation than those on unlocked rehabilitation units did (Dunnett T3 = 1.14, p = .004). All remaining domains of the LQOLP and all domains of the
WHOQOL-BREF were not significantly different by type of unit. LQOLP scores by unit type are given in Table 4.

**Therapeutic Relationship**

Scores obtained for the TRQ are given for the current sample and by security level in Table 5. Mean scores and standard deviations are shown for each question (e.g., Treatment, Understanding, and Respect) and for each type of professional a patient has regular contact with.

**Table 5. TRQ scores for current sample and by type of unit**

<table>
<thead>
<tr>
<th>Question</th>
<th>Current sample N = 44</th>
<th>Acute/Secure N = 8</th>
<th>Rehab/Unlocked N = 31</th>
<th>Long-term/Open N = 7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Treatment</td>
<td>7.81</td>
<td>2.05</td>
<td>8.46</td>
<td>1.38</td>
</tr>
<tr>
<td>Understanding</td>
<td>7.70</td>
<td>2.08</td>
<td>7.79</td>
<td>1.72</td>
</tr>
<tr>
<td>Respect</td>
<td>7.87</td>
<td>2.21</td>
<td>8.54</td>
<td>1.58</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Profession</th>
<th>Current sample N = 44</th>
<th>Acute/Secure N = 8</th>
<th>Rehab/Unlocked N = 31</th>
<th>Long-term/Open N = 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatry</td>
<td>7.27</td>
<td>2.84</td>
<td>7.58</td>
<td>2.36</td>
</tr>
<tr>
<td>Psychology</td>
<td>8.08</td>
<td>2.46</td>
<td>7.72</td>
<td>2.61</td>
</tr>
<tr>
<td>OT</td>
<td>8.11</td>
<td>2.17</td>
<td>8.38</td>
<td>1.70</td>
</tr>
<tr>
<td>Keyworker</td>
<td>7.77</td>
<td>2.59</td>
<td>8.62</td>
<td>1.83</td>
</tr>
</tbody>
</table>

Global well-being scores from the LQOLP correlated significantly with Treatment ($r = .347, p<.05$), Understanding ($r = .460, p<.01$), and Respect ($r = .412, p<.01$). Global well-being scores from the LQOLP also correlated significantly with overall ratings for Psychiatry ($r = .371, p<.01$) and OT ($r = .434, p<.01$) but there was no relationship found with Psychology or Keyworker.

There was no significant difference between question type or profession group for therapeutic alliance scores. Scores were summed to give an overall score for Therapeutic Relationship. Significant correlation ($p<.05$) was found between Therapeutic Relationship and all domains of the LQOLP except Work. Therapeutic Relationship correlated significantly with WHOQOL-BREF domains Physical ($r = .343, p<.05$) and Environment ($r = .539, p<.001$) but not Social or Psychological. No significant correlation was found between type of unit and Therapeutic Relationship and Therapeutic Relationship ratings did not vary by type of unit ($F(2) = .697, p = .504$).
Discussion

This study was part of a larger investigation, which aims to measure and monitor subjective QoL for in-patients at a local RSU annually. Comparing the LQOLP scores with those obtained last year, no statistically significant differences were observed. Scores for the current sample suggest that perceived quality of leisure, living situation and financial situation has improved since the evaluation last year but other domains are rated as less favourable compared to last year. Similarly, scores for the WHOQOL-BREF are not significantly different but are lower than last year’s ratings.

The largest difference between last year and the current study is for the LQOLP domain of finance. This difference most likely reflects the recent changes in patient benefit entitlements. As a result of these changes the majority of patients have seen an improvement in the amount of money they are entitled to claim.

Although the perceived quality of leisure and living situation is rated higher than last year, social relations are rated as poorer on both the LQOLP and WHOQOL-BREF. Psychological well-being as measured on the WHOQOL-BREF is also rated as poorer and the correlation between this score and the score for social relations suggest that this might be a fruitful area for further investigation. Opportunities for social relations and frequency of organised social events could be compared or manipulated across different units to see if this might impact on perceived quality of social relations, psychological well-being and global well-being.

The lowest rated domain by the current sample was for work. Although none of the patients at the RSU are employed, patients were asked about their perceived quality of the occupational therapy available to them. In the current sample satisfaction in this domain was found to vary significantly according to unit type with those on open wards being the most satisfied with their ‘work’ and those on locked units being the least satisfied. This finding is not surprising given that those patients on less secure units do have more opportunity and freedom to engage with occupational therapy.

The other significant difference between unit type and LQOLP domains, however, is less easily explained. For living situation, the acute/locked unit patients report significantly higher satisfaction than those on open and rehabilitation units do. It is difficult to speculate why the patients in a more restricted environment might be more satisfied than patients with more freedom are. There was a smaller proportion of patients from acute/locked units than from rehabilitation or open units who consented to participate in the study. This finding, therefore, might suggest that the respondents from the acute units are not representative of patients in this setting. Alternatively, the restrictive living environment of the RSU might be more satisfactory to those who are the most unwell and less satisfactory to those who are in
recovery and who may be looking forward to life outside the RSU with even fewer restrictions on their freedom. A future investigation of this finding might benefit from qualitative methods to help understand the different perceptions of patients in different unit types and perhaps the different needs of these groups.

It was suggested that quality of therapeutic relationships might be an important consideration for this sample given that quality of therapeutic relationship has been reported to be a good predictor of successful outcome (Frank & Gunderson, 1990). This is somewhat supported by the significant correlation between most QoL domains and therapeutic relationship scores.

It is interesting that the ratings for psychiatrist and OT were significantly related to global well-being whereas ratings for psychologist and keyworker were not. This finding might suggest that perceived QoL in the RSU is associated by the quality of relationship a patient has with their psychiatrist and their OT. This would seem a plausible hypothesis as it is these professionals who are most directly and routinely connected with a patient’s restriction level (psychiatry), daily schedule and the opportunities and facilities a patient can engage with (OT). Many patients do not have regular input from their psychologist and contact with keyworker will depend on shift patterns and nursing demand.

It might have been expected that type of unit would significantly influence rating of therapeutic relationship, but this was not found to be the case. There were, however, some interesting differences between units. Patients on open units gave the highest ratings to OT, patients on acute units gave the highest rating to their keyworker and patients on rehabilitation units gave the highest rating to their psychologist. This pattern might reflect the different needs of patients or the availability of types of professional to patients on different units.

Previous research suggests that length of admission might be an important factor when considering therapeutic relationship and that significant relationships between QoL and therapeutic relationship might be observed in long-term patients (McCabe et al., 1999). Unfortunately it was not possible to access data about length of admission to perform this analysis, however, this might be a possibility in future evaluations.

This was the first time that the RSU attempted to evaluate therapeutic relationship and further research is needed to explore this area. In this study therapeutic relationship was measured using a separate questionnaire and a different measurement scale than the one used to investigate QoL. During the data collection it was felt that it might have been easier for patients if the same rating scale was used throughout so that patients could have indicated their satisfaction with professionals in the same manner in which they indicated their satisfaction with domains of their life. Another possible difficulty is that despite reassurances of confidentiality, patients may have been concerned that their ratings would be fed back to the professionals responsible for their care and that this may have had a detrimental impact on
them. One way around this would be to give patients questionnaires which they could complete alone and anonymously and post in box, however, this would exclude patients who might have difficulty with reading.

This study has several limitations. First, RSU staff conducted the research and as suggested above in respect to therapeutic relationship, patients may have given different ratings if the research had been conducted independently. Second, although over half the patients consented to participate in the study there is no data here from 42% of the patients. It could be hypothesised that those patients who did not participate, although not significantly different in terms of ethnicity or age, might differ significantly in terms of their perceived QoL. Whilst this issue is typical in much research it is important that future evaluations attempt to collect data from as many patients as possible. Fewer patients consented to take part this year as compared to last year. One reason for this might be that last year keyworkers collected data whereas for this study psychology staff conducted the data collection. One possible solution might be to give all patients a very short and simple measure that could be completed anonymously as well as being invited to participate in a larger study. This strategy might provide some insight into whether non-participators are generally less satisfied.

A final limitation considered here is that there are several clinical variables shown to be important predictors of QoL in outpatient samples (e.g., perceived distress, depression, anxiety, medication, activity level) which are not considered here. These variables are being investigated as part of the larger study into QoL at the RSU and a consideration of all of these variables might provide a more holistic understanding of subjective QoL for patients in secure care.

**Conclusions**

This study has several implications for service provision and development at the RSU. The QoL findings are not significantly different to those reported in previous years and, therefore, the small differences observed might be due to any number of factors. The differences, however, do highlight some trends, which could be monitored in future evaluations (e.g. decrease in perceived satisfaction with social relations).

In addition, the unexpected finding that patients in a more restricted environment report greater satisfaction with their living situation might suggest that future evaluations should focus on getting more of the acute patients to participate in evaluations so that these findings can be tested. It might also suggest that efforts to improve patient quality of life might need to focus on different domains for different unit types.
Considering therapeutic relationship the results here are first attempts at capturing the amount of satisfaction that patients have with the professionals who care for them. The lack of significant results is disappointing, as it is not possible to offer clear suggestions for service provision and development. The results do suggest tentatively that patients on different types of unit have different relationships with different types of professional and it would be useful to investigate this further. Given the challenges in asking patients to report honestly the quality of relationships they have with professionals, future studies may benefit from using different methods (e.g. collecting data anonymously) although any method will have its disadvantages.
References


CPR 3: Case Study

An 11-year-old boy with learning disabilities presenting with challenging behaviour at school
Abstract

This case study considers Peter, an 11-year-old-boy who presents with challenging behaviour at school. Peter’s Statement of Special Educational Needs describes him as having Severe Learning Disabilities and Significant Behavioural difficulties. Information about the referral, the assessment and a suggested formulation are set out. Ideas for intervention that are suggested by the formulation are also discussed. The intervention plan included strategies taken from work with children who have attention difficulties and a Positive Behavioural Support approach. The school that referred Peter, however, did not wish to implement the intervention package that was suggested and chose to continue with their current strategies. Reflections about this piece of work and ethical issues that arose are also presented.

To maintain client confidentiality, all names and locations have been changed.
Referral

The current referral came from the head teacher at Peter’s school. The school is a special school and Peter has been a pupil there for five years. Last October Peter started in a new class and his classroom teacher has been struggling to manage; Peter often runs out of the class, bangs doors, screams and lies on the floor. In particular, running away from the classroom was a cause for concern and a potential high cost risk given that Peter has previously run out into the school car park.

This type of referral would typically be made to an Educational Psychologist from the Education Authority rather than to a Clinical Psychology Service. The Community Psychology team, however, decided to accept the referral as Peter was already known to the team (the team had previously worked on his toileting difficulties).

Initial Assessment

Assessment sources

Peter’s mother and stepfather and also Peter’s father were interviewed as were Peter’s head teacher and classroom teacher. Peter’s classroom teacher was also asked to complete the Motivation Assessment Scale (Durrand & Crimmins, 1992). Information was also available from a local Educational Psychology Service report that included the Vineland Adaptive Behaviour Scales (Sparrow, Balla, & Cicchetti, 1984). Two direct observations of Peter in the classroom were carried out in December and January.

Family Background

Peter is the son of Eva and James. Eva and James separated and divorced when Peter was four years old and both of his parents have remarried since. Peter lives with his mother and his stepfather David, however, his father and paternal grandmother also play a large role in caring for him. Each weekday after school for a few hours, Friday evenings and alternate weekends Peter stays with his father, stepmother and their two-year-old son. On alternate weekends Peter stays with his paternal grandmother Pat and his grandfather. Pat has always played an active role in caring for Peter; she cared for him daily from the age of six months so that Eva could return to work. Eva’s family does not originate or live in the UK and they have no role in Peter’s everyday life.

His family describes Peter as happy, excitable, loving, and “full of energy”. The family seems to function well in supporting and caring for Peter despite a variety of opinions
about his care and schooling. Peter’s mother, father and stepfather all have successful careers and University level education.

Figure 1. Peter’s Family Genogram

![Peter’s Family Genogram](image)

**Current situation**

Peter spends his school day in a class with ten other pupils and four members of staff. Although there seem to be periods of time when Peter will engage well in a class task, his behaviour is often disruptive. Between September and December, for example, 266 incidents were recorded by the school as requiring “Team Teach” (a behaviour management approach which emphasises positive handling). At the end of the school day staff are often exhausted and the head teacher is very concerned that Peter’s behaviour will result in staff burnout.

Peter’s parents are also unhappy with the current situation. When Peter returns home after school he often says “no treat” and he seems increasingly reluctant to go to school (“no school”). Although David and Eva are not happy with the school’s management of Peter they have maintained a working relationship with the school. The relationship between Peter’s father and the school, however, has broken down and James has made a complaint against the school. James argues that Peter should be treated as a two-year-old “because this is his level” and he thinks that the school is placing inappropriate demands on Peter.
Health and Development

Peter’s severe learning disability is the result of a Neuronal Migration disorder. In addition Peter has Epilepsy (following West Syndrome) and, up until the last six months he typically had one seizure per week. Currently Peter is said to be “well managed” on anti-epileptic medication (Levetiracetam).

Peter has global developmental delay; in all domains measured by the Vineland Adaptive Behaviour Scales there is significant delay (Communication 1.11 years; Daily Living Skills, 2.0 years; Socialisation domain, 2.04 years; Motor Skills 2.07 years). Peter also has many features of Attention Deficit and Hyperactivity Disorder (ADHD); he has poor impulse control, short attention span, and a high activity level.

Despite these difficulties Peter can perform well in some classroom activities. Peter’s relative strengths are in his expressive language skills (2.03 years) and his social skills and, when it is also an activity that Peter enjoys, he can participate and engage well. During simple games, for example, he will use the names of the other players, take turn with no difficulty, follow the rules of the game, will apologise if he makes a mistake without prompting and can remain fully engaged in the game for at least ten minutes. He is motivated by praise and will often request adult verbal praise when he has achieved a task.

Observations

The focus of the current work was on Peter’s ‘running off’ as this was the behaviour with the highest risk cost. There are, however, a number of disruptive behaviours, for example: banging doors, kicking walls, screaming, and throwing objects. The initial observations set out to record all of these behaviours (an example of the recording sheet is given in Appendix 6).

During my first observation Peter spent 56% of the afternoon session in the classroom and in the second observation he spent 48% of the afternoon session in the classroom. During his time outside the classroom Peter is typically running around the corridors of the school and banging classroom doors or he is lying on the corridor floor. He is often laughing or making a high pitched noise and to all concerned it seems clear that this is a fun game for Peter.

At the time of the first observation (December 2006) when Peter ran to the corridor, staff would try to encourage him to a separate room. Once in this room staff would try to engage Peter in a game until they felt it was time to try and return him to class. At the second observation (in January 2007) staff were trying a new strategy and were proactively removing Peter to a different room when they thought he was restless. It was hoped that this strategy might avoid disruptive behaviour in the corridor. This approach, however, resulted in Peter
spending even less time in the classroom and did not avoid disruption in the corridors. During both observations, at least one member of staff was occupied solely with managing Peter for more than ninety percent of the time.

Motivational Assessment Scale and Staff Attributions

Peter’s class teacher was asked to complete the Motivation Assessment Scale (Appendix 7) to consider the function of Peter’s running away behaviour. The results from this short form suggest that the most important influences on this behaviour are tangible rewards and attention. In interview the teaching assistants also mention escape (i.e. avoidance of some tasks) as a function of Peter’s behaviour but they agree that the most important influence for Peter is to gain access to a desired activity (i.e. playing) or to gain attention. Although staff attributions were not formally assessed, all of the staff believe that Peter is able to control his behaviour. These beliefs are based on their observations that Peter can (“when he wants to”) engage in activities well. In addition the staff feel that Peter does understand the current reward system. This system means that if Peter is good for the afternoon session he is allowed to choose a treat for the last twenty minutes of the school day. Peter will often say “no treat” when he has run off which is also cited by the staff as evidence that he understands when his behaviour is not acceptable and that he can control this.

Initial Formulation

Peter’s running away behaviour is the focus of this formulation. This behaviour was the most risky and with a potentially high cost; Peter had recently run out of a fire door and into the school car park. In addition, this behaviour often requires management by two members of staff at a time and, therefore, is very costly to the staff and the other pupils in Peter’s class.

The information gathered from the assessment stage was summarised using Carr’s (1999) model for considering the influences on problem development in children and adolescents (see Figure 2.). This diagram provided a useful way to organise the predisposing, precipitating, maintaining and protective factors (both personal and contextual) which might be influencing this behaviour.
Personal predisposing factors

Biological
- Neuronal migrational disorder
- West syndrome (seizures)

Psychological
- Short attention span (unless highly preferred activity)
- Poor impulse control
- Likes high level of activity – seeks movement sensation
- Noise/touch sensitivity

Contextual predisposing factors

Parent-child factors in early life
- Inconsistent parental discipline

Exposure to family problems in early life
- Marital discord
- Parental separation when Peter age 4

Personal maintaining factors

Biological factors
- Difficulty maintaining attention
- Running off provides movement sensation

Psychological factors
- Learned failure (“no treat”)
- Misbehaviour leads to preferred interactions/avoids undesired tasks

Contextual maintaining factors

Treatment system factors
- Lack of co-ordination/ lack of consistent response
- Conflict between family and school
- No reward for positive behaviour

Family system factors
- Inadvertent reinforcement
- Inconsistent discipline

Parental factors
- Father’s cognitive distortions – 2yr old

Personal protective factors

Biological factors
- Good general health (eats well, sleeps well, robust)

Psychological factors
- Good social skills
- Understands simple cause and effect, associations, instructions
- Motivated by praise
- Visual cues work well

Contextual protective factors

Treatment system factors
- Family/school accept there is a problem
- Family/school committed to resolving the problem

Family system factors
- Father involvement
- Clear family communication
- Flexible family organisation

Parental factors
- Good parental adjustment
- High parental self-efficacy and self-esteem
- Functional coping strategies

Social network factors
- Low family stress
- High SES

Problem behaviour
- Running off in class (disruptive behaviour in corridor, kicking walls/door, banging doors, screaming, lying on floor)
Considering the predisposing factors, Peter’s biological condition is quite complex and there are several possibilities as to how this might be impacting on the running behaviour. One hypothesis might be that Peter finds it very difficult to control an impulse to run off; Peter is very active and high levels of activity are rewarding for Peter. During my observations I was very struck by Peter’s difficulty in inhibiting responses in a game he was playing. The object of the game was to listen to a command (e.g., put your hands on your head) and then wait for the prompt “now” before carrying out the command. Each time Peter was unable to wait for the prompt and carried out the command immediately. Thus, it appears to be very difficult for Peter to inhibit his impulses even when he is engaged and motivated.

Peter’s running off in class had been a difficulty for the school in previous years, since the start of the school year, however, this problem had become much worse. Around this time Peter’s medication was changed but Peter’s parents claim that his behaviour did not worsen at home and, therefore, that it is the change in classroom environment which was the main precipitating factor.

The observations and assessment of the functions of the behaviour suggest that in the classroom, Peter’s running off might be maintained through positive and negative reinforcement. Essentially the hypothesis is that when the environment is not rewarding for Peter, Peter makes his own reward (i.e., by running off and initiating a game of chase through the corridors). The establishing operation (EO) for Peter’s running off is, therefore, reinforcer deprivation. The new classroom environment that Peter encountered in September might have been more demanding and less rewarding for Peter so that the EO was more often present from this time.

When Peter runs out of the classroom his behaviour is negatively reinforced when he avoids doing a non-preferred task and positively reinforced because staff must respond to this behaviour and so he is guaranteed attention. The physical act of running might also be an internal positive reinforcer for Peter.

A diagrammatic representation of how Peter’s running away might be maintained through positive and negative reinforcement in the short and long term is shown in Figure 3. This behavioural formulation also considers that staff responses might be playing a part maintaining Peter’s behaviour. Staff efforts to engage Peter and end his disruptive behaviour in the corridor do eventually result in Peter returning to the classroom and this, therefore, ends the aversive experience for staff and, therefore, negatively reinforces their methods.

Another possible maintaining factor is the staff inconsistent approach; during the observations different strategies were noted. Staff sometimes ignored Peter as he initially ran out of the classroom whereas on other occasions they would immediately follow him and try to encourage him to return. This inconsistency is reinforcing Peter’s behaviour on an intermittent (VI) schedule. Such a schedule will make it more difficult to extinguish this
behaviour than if the staff had immediately followed Peter every time (i.e. continuous reinforcement).

A final aspect of the initial formulation suggests that Peter’s running away behaviour might also be maintained by staff attributions of controllability. Attribution theory suggests that controllability is “of prime importance” in determining helping behaviour (Weiner, 2000). Research has suggested that controllable child-centred attributions are more likely to result in over-reactive and harsh responses by adults (e.g., Johnston, Patenaude, & Inman, 1992; Smith & O’Leary, 1995). It is hypothesised here that the attribution of controllability means that the staff are reluctant to provide Peter with activities that he enjoys as they perceive that this would reward his misbehaviour. Staff increase the likelihood of future running away incidents, however, by trying to get Peter to complete non-preferred activities or by denying him access to his preferred activities and, therefore, by creating the EO. In addition, if staff choose to punish Peter for running away by removing his treat at the end of the day, Peter has no reinforcement contingency to encourage him to remain in the classroom. Once Peter has misbehaved, therefore, and knows he has lost his treat (“no treat today”) there is no motivation for Peter to complete any non-preferred task.
Long term effect of adults’ behaviour on child’s behaviour

Immediate effect of adults’ behaviour on child’s behaviour

Child’s behaviour

Adults’ behaviour

Immediate effect of child’s behaviour on adults’ behaviour

Long term effect of child’s behaviour on adults’ behaviour

As a result of positive (sensory stimulation and social interaction) and negative reinforcement (avoidance of non-preferred task), running away is more likely to occur when reinforcer deprivation occurs in the future. Staff inconsistency also means that the reinforcement contingent is likely to be a VI schedule.

Prior to Peter running off he is not engaged in a reinforcing activity. This represents an EO of reinforcer deprivation.

Peter runs out of classroom, banging other classroom doors, lying on floor.

Staff follow Peter and try to get him out of the corridor and to an alternative room. A staff member then plays a game with Peter and then tries to return Peter to the classroom.

Peter engaged in game/task with staff.

Returns to classroom.

Peter back in class engaged in activity. This is an AO as the aversive stimulus has been removed. This negatively reinforces the staff approach.

Reinforcer is gained and deprived state is satiated, therefore and AO. Running away was positively reinforced (sensory stimulation and social interaction) and negatively reinforced (avoidance of non-preferred task).

Peter runs out of classroom, banging other classroom doors, lying on floor.

Staff follow Peter and try to get him out of the corridor and to an alternative room. A staff member then plays a game with Peter and then tries to return Peter to the classroom.

Peter engages in game/task with staff.

Returns to classroom.

As being changed or dressed is terminated, the establishing operation is no longer operating and behaviour ceases.

Time

As a result of positive (sensory stimulation and social interaction) and negative reinforcement (avoidance of non-preferred task), running away is more likely to occur when reinforcer deprivation occurs in the future. Staff inconsistency also means that the reinforcement contingent is likely to be a VI schedule.

Prior to Peter running off he is not engaged in a reinforcing activity. This represents an EO of reinforcer deprivation.

Peter running off is aversive to staff and therefore an EO that provokes the provision of 1:1 social interaction and the offering of an activity to Peter.

Peter back in class engaged in activity. This is an AO as the aversive stimulus has been removed. This negatively reinforces the staff approach.

Staff attributions about Peter running away are controllable. Therefore, they feel Peter should be made to complete work tasks/preferred activities should be limited/treats should be denied.

As a result of the negative reinforcement from the termination of the Peter’s running away, staff are more likely to provide social interaction if Peter run’s away in the future.
**Intervention**

After the initial formulation, the plan for intervention was to share part of the formulation with Peter’s classroom teacher and head teacher and then to work with the school to devise a plan for managing Peter’s running away behaviour. A diagram (see Figure 4.) was used to illustrate part of the formulation to Peter’s teacher. The diagram aimed to show how Peter would need to complete several non-preferred tasks in order to gain a reward from the classroom system where as running away in itself might be rewarding in several ways. It was also hoped that the diagram would help prompt staff to think about the challenges that Peter faces in the classroom and, therefore, to challenge ideas about controllability. Peter’s distractibility, his poor impulse control and the difficulty in remembering the sequence of events that will lead to a classroom reward are all working against Peter being able to meet the classroom demands.

A number of strategies are suggested here which, based on the formulation, might help reduce Peter’s running away behaviour and generally improve his engagement in the classroom. Some general intervention ideas are taken from the literature on managing children with attention and overactivity problems (Carr, 1999) and built into a suggested package of Positive Behavioural Support (McClean & Grey, 2007) (see Table 1.). The overall plan for intervention would be to build on Peter’s strengths (e.g., understanding of simple cause and effect, good social skills, appreciative of adult praise) and to take a constructional approach in reducing the problem behaviour by adapting the environment and teaching new skills (Carr et al., 1999). Consistency would be an important requirement for any intervention with Peter and, therefore, any plan would need to be supported by all of the staff involved.

Intervention strategies for children with attention difficulties emphasise that intervention plans should reward positive behaviour whenever possible; staff should be monitoring behaviour all the time for opportunities to reward. In addition, if punishment is used then an opportunity to reward positive behaviour should be identified as soon as possible (Carr, 1999).

A suitable reward system is essential and ideally should be agreed between the school and the parents. In order to minimise classroom disruption, stickers could be awarded in a low-key manner at school and these could be exchanged for a reward at home. For children with attention difficulties it is essential that the token or point be given immediately following an identified target behaviour (e.g., remaining in seat for five minutes). Similarly such a system can be used to reduce identified problem behaviours (e.g., sticker removed if leaves classroom at inappropriate time).
Figure 4. Diagram to illustrate the classroom reward system compared with ‘Peter’s reward system’
For children with attention difficulties it is also important to use commands effectively so that instructions are clear and simple (e.g., no qualifiers) and are only given when the child is engaged. In addition, any punishment such as removal of tokens or time out should be preceded by two warnings, which should also be clear and simple.

A package of intervention, however, which considers Peter’s range of disabilities and not just his attention deficits is more likely to be successful. Recent and emerging literature supports the use of Positive Behavioural Support as a model of intervention for individuals with intellectual disability and challenging behaviour (McClean & Grey, 2007). La Vigna & Willis (1995) suggest that intervention plans following this model should contain elements from four components. The first three components make up a proactive plan designed to reduce the likelihood of the problem behaviour and the final component is a reactive strategy. The proactive elements include environmental accommodations, skills teaching and direct interventions. A summary of the suggested behaviour support plan is given in Table 1.

For Peter, the intervention plan following this approach could include environmental accommodations such as more choice of activity and variety of activity. An activity sampling method could be used to identify the possible options. Peter very much enjoys working with the computer and this could be used more to engage him in class.

Picture sequencing is another environmental accommodation that might help with transitions from one activity to the next. A simple “now and next” system would be understood easily by Peter. In addition a general protocol for transitions would help Peter change activity smoothly and might reduce running off behaviour at these times.

In terms of direct intervention, there are two strategies that might help support Peter’s positive behaviour: stimulus satiation and differential reinforcement. Stimulus satiation could involve frequent activity breaks so that Peter has scheduled time periods when he can “let off steam” in a supervised manner. As well as potential immediate benefits there are possible longer term gains in that this strategy might help Peter to learn about his own activity level and manage his own behaviour.

A differential reinforcement procedure could help build on the amount of time that Peter is behaving well in class and is engaged in tasks. A reward schedule would need to be developed with the school and ideally Peter’s family and, given Peter’s difficulty in maintaining attention, any plan should consider the suggestions listed earlier for children with ADHD. The reward would need to be something that is motivating for Peter, something that
<table>
<thead>
<tr>
<th>Category</th>
<th>Intervention</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental accommodation</td>
<td>Choice of activity offered</td>
<td>Behavioural assessment indicates that Peter is not likely to run off when he is engaged in a preferred activity.</td>
</tr>
<tr>
<td>Environmental accommodation</td>
<td>Variety of activity offered</td>
<td>Peter is described as being motivated by new things and new situations and, therefore, he is less likely to run off if he is stimulated.</td>
</tr>
<tr>
<td>Environmental accommodation</td>
<td>Picture sequencing – “now and next” cards</td>
<td>Pictures will support Peter to understand predict what will happen next and what is required of him. This could be also used to cue Peter to upcoming preferred activities (e.g., now story, next computer).</td>
</tr>
<tr>
<td>Environmental accommodation</td>
<td>Transition protocol</td>
<td>Helping a smooth transition between activities might reduce Peter’s likelihood of running off. A planned procedure (perhaps with extra staff for a short time) would support Peter to stay engaged with class activities.</td>
</tr>
<tr>
<td>Functionally equivalent skill</td>
<td>Choice of activity</td>
<td>Giving Peter a choice of two activities would help him communicate his needs to staff (e.g., could choose activity break rather than running off).</td>
</tr>
<tr>
<td>General skill</td>
<td>Picture Exchange Communication</td>
<td>Teaching PECS could give Peter an effective way to communicate his needs to other people.</td>
</tr>
<tr>
<td>Direct intervention</td>
<td>Stimulus satiation</td>
<td>Frequent activity breaks might support Peter’s need and enjoyment of movement in a safe manner and enable him to be more focussed when back in the classroom.</td>
</tr>
<tr>
<td>Direct intervention</td>
<td>Differential reward of other behaviours</td>
<td>Reinforcement of appropriate classroom behaviours might help Peter maintain motivation during less preferred activities.</td>
</tr>
<tr>
<td>Reactive strategies</td>
<td>Time out</td>
<td>A brief period of time if Peter does run out of the classroom might reduce the likelihood of this behaviour. Clear protocols for this should be developed with the school but it should include clear warnings, only a brief time period and positive reinforcement of desired behaviour as soon as possible after the time out has finished.</td>
</tr>
</tbody>
</table>
would only be available if the goal is reached and something that if not attained would not diminish Peter’s quality of life.

To incorporate some skills teaching into Peter’s plan this could include general communication skills and specific skills. Peter’s school often uses PECS (picture exchange communication system) and this might be something that could be started with Peter, particularly once a reinforcement system that supports his learning is developed. Improving Peter’s communication skills might enable him, for example, to let staff know when he needs a activity break. Specific skills training might also focus on teaching Peter tolerance and how to cope with delay.

The final component of the plan considers how staff might respond if Peter does run off. Given the potentially dangerous nature of this behaviour a punishment procedure such as timeout could be considered here. According to Carr (1999), timeout for children with attention difficulties can be a useful strategy if two clear warnings are given first, the timeout is brief and, after the timeout an opportunity is sought as soon as possible to reinforce desired behaviour. Regarding the length of a timeout for Peter this should be very brief and two minutes might be sufficient for his development level. Such a strategy would need to be monitored and reviewed if it failed to significantly reduce the behaviour. Indeed all aspects of the plan should be monitored and initially, weekly reviews would be planned.

When the formulation (as depicted in figure 4.) was shared with Peter’s head teacher and classroom teacher, both agreed that this fitted with their understanding of Peter’s behaviour and that Peter’s running off was essentially to reward himself when the environment was failing to do so. I was informed at this meeting, however, that Peter’s behaviour was no longer a problem and that the school did not need any help with an intervention plan. Unbeknownst to the psychology team, the school had also sought advice from a school for children with special needs. Their advice had been to implement the use of “now and next” pictures and to use more frequent rewards so that Peter did not wait till the end of the day for positive reinforcement of desired behaviour. According to both teachers this intervention had quickly improved the situation with Peter and they did not want to change anything now that they had found something that worked.
Although the school said that they did not require any further input I was interested to see how Peter was in class following their intervention and I asked if I could conduct another observation to see the changes. The school agreed and I conducted a final observation.

When I carried out my third observation Peter’s class teacher was away and Peter had a different teacher though the same assistants were present. Since my previous observation the school had also organised an extra member of staff so that Peter always has a teaching assistant working one-to-one with him. Another further change was that the classroom had been reorganised so that one corner had been sectioned off to provide a “workstation” for Peter.

The observation turned out to be very different to what I had been expecting. I observed Peter for one hour and forty-five minutes and of that time he spent an hour in the workstation alone and distressed. For most of this hour Peter was screaming and banging the wall/banging the cupboard door and occasionally throwing objects (e.g. chair). The workstation area was essentially being used as a timeout area and whilst he was in this space his one-to-one assistant stood at the door to the area and faced out away from Peter and ignored him. Later in the afternoon the assistant explained to me that it was a “battle for control” with Peter.

During the hour that Peter spent in the workstation the staff tried to reintegrate Peter twice into the class activity of painting but on each occasion Peter seemed overexcited to be free from the workstation, kicked the heater and was returned immediately and without warning. Peter’s distress and frustration was clearly evident: “lost it”, “no painting”. On one occasion, having been returned to his area Peter tried to complete a puzzle in an attempt to please the assistant (“look Mary look”) but he continued to be ignored.

After an hour Peter rejoins the class for a story telling and Peter participates well with this and then several other activities. There were several other occasions where Peter is returned to the workstation as punishment without warnings.

Immediately after the observation Peter’s usual class teacher came to meet me. He explained that usually things have been much better and that today had been a “bad day”. I reported that I hadn’t observed the use of rewards for positive behaviour or the “now and next” cards which I had been told were working well. He said that they had used these methods for a week but the situation had improved and it was “unfair” that Peter should get more rewards than the other pupils and that it was better for his “social integration” that he was rewarded in the same manner as his peers.
Discussion and Reflections

This case stirred up a great deal of feeling in me and, as I left the school after my final observation, I felt very angry, frustrated and powerless. I spent a great deal of time over the following days with my supervisor discussing what had happened and how we could manage the situation. Recently the community psychology team had taken several referrals from this school and this was not the only case where the school had been very eager to engage at the assessment stage but unwilling to follow through with any intervention. Ultimately as part of the health service rather than the education system, we were working outside our remit and essentially had no power to make the school follow any suggestions made by the team.

My supervisor asked me if I felt that the school’s treatment of Peter had “crossed the line” and was effectively abusive. On reflection I decided that this was the case and that further action did need to be taken. My greatest concern was the overuse of punishment by the school. Timeout interventions usually suggest a minute of timeout per year of age (and this should be considerably less if the individual has an intellectual disability). The hour that Peter spent in his “workstation” was clearly not appropriate. I was asked to write a report of my observations and I detailed what I had seen and summarised my main concerns which were: overuse of punishment strategies, extended periods of punishment, lack of warning before punishment and, no reward for positive behaviour.

After discussion with the community psychology team it was decided that the manager of the service would meet with the head teacher to discuss Peter’s case and also to consider how the team could work with the school in the future. At the time of writing a telephone call has taken place between the manager and the head teacher. The school agreed that the practice I had observed was not acceptable and claimed that the workstation would not continue to be used as a means of secluding Peter. This is as much detail, however, as I know. On reflection I feel that this case, along with several others from my learning disability placement, hinged on the attributions of other people. Looking now at my intervention plan I feel I was somewhat unrealistic. Although I had identified staff attributions in my formulation as contributing to the difficulties with Peter, I didn’t plan any intervention to address this. On reflection, although I was limited by time I think that my knowledge and skills of how to tackle this also limited me. This is a gap, which I feel I need to address in the future to be an effective practitioner when working through staff, carers, parents or teachers.

Attribution theory is an established concept and the beliefs that we have about an individual will play an important role in influencing how we treat that individual. The dimension
of controllability, in particular, is of key importance (Weiner, 2000). The same phenomenon is reported in the literature from child psychology regarding parent attributions (e.g., Smith & O’Leary, 1995), the literature from learning disabilities regarding carer attributions (e.g., McGuinness & Dagnan, 2001) and the literature from educational psychology on teacher attributions (Male, 2003). This phenomenon is essentially that, when attributions about an individual’s behaviour are that it is controllable the affective response is anger and the behavioural response is to punish.

For Peter, unfortunately, staff believe that his behaviour is controllable. Because he can sometimes engage and behave well in class and because he understands when he is being punished (“no treat today”, “Peter sad”, “lost it”), it seems to me that the staff fail to appreciate how difficult it is for Peter to fit with their demands. I wonder if part of the reason the staff are failing to consider Peter in a sympathetic way is connected to the difficult relationship that the school has with his father. It seems reasonable to suggest that the complaint that Peter’s father has made against the school might add to the negative feelings staff have towards his son.

McGuiness & Dagnan (2001) describe a cognitive staff-training package to address the way that care staff respond to difficult child behaviour. As part of this package they target the attribution of controllability and help carers to examine the ability and history of a child so that their behaviour can be put in a functional context. This often challenges the assumption that the child can control their behaviour. On reflection, doing this type of work with the teaching staff might have produced a more successful outcome for Peter.

This was a very interesting case and there are other issues and reflections that I have not been able to explore here. When I first received the referral information, for example, I was concerned about Peter’s medication and how this might be influencing his behaviour. This issue, however, was never really explored. Coming from a placement at a medium secure unit where considerations about medication were at the forefront of treatment discussions, this was a real contrast and I wonder in hindsight if I missed an opportunity at this placement to meet with psychiatry and discuss my concerns.

A final reflection is that this case study has been quite timely as it has coincided with planning the placements for the remainder of my training. Many of the options that I might like to pursue in my career would likely involve some working within systems and this piece of work has helped to highlight some of the skills I would like to develop in my next placements. In particular I feel that, in the future, having some experience with a systemic approach might help me tackle some of the issues that I have struggled with here.
References


CPR 4: Single Case Experimental Design

Using the Solihull Approach to intervene with a toileting problem in a 4-year-old girl
Abstract

The Solihull Approach was used to intervene with a four-year-old girl experiencing a toileting problem. The intervention was evaluated using a single case experimental design. The family were asked to keep a toileting diary and data was recorded for four weeks prior to the intervention (baseline) and then for four weeks during the intervention phase. Visual inspection of the data showed there was no difference in the toileting problem from the baseline to the intervention phase of the study. A discussion and reflection of these findings is provided.

To maintain client confidentiality, all names and locations have been changed.
Referral

Jessica was referred to CAMHS (Child Adolescent Mental Health Services) by a Health Visitor. Jessica’s family was visited at home for a ‘triage’ session to determine if a referral to Child Psychology was appropriate. The triage session identified the reason for referral as a toileting problem that had started eighteen months ago when Jessica was around two and a half years old. During this time Jessica has been seen by a Paediatrician and has been prescribed laxatives but these have not helped. The outcome of the triage session was to refer the case to Child Psychology.

Initial Assessment

Jessica attended the initial assessment session with her parents Helen and David and her three sisters. Although Helen and David were happy to be seeing a psychologist there was uncertainty as to whether the problem might be a medical one. Specifically there were concerns that Jessica might have Hirschspring’s disease. The family agreed, however, that even if the cause was a medical one, there were likely psychological consequences (e.g., Jessica was clearly anxious about going to the toilet). It was agreed, therefore, that the initial assessment would proceed and that during the following two weeks the family would complete a toileting diary to monitor when Jessica was soiling. The Health Visitor was assessing Jessica’s diet and a biopsy to test for Hirschspring’s was scheduled to occur in the next three weeks. We agreed to meet after the family had received the results of the biopsy to re-evaluate the situation and the need for intervention.

Presenting Difficulty

Helen described trying to start toilet training with Jessica when she had been two-years-old. Helen soon realised, however, that this was “not happening” and stopped the training for six months. When Jessica was two and half Helen and David tried again and although they were successful in teaching Jessica appropriate toilet use there were recurring problems with soiling and constipation. Helen and David recalled an incident on holiday when Jessica had experienced great difficulty passing a painful stool. Helen and David recalled that this occurred around the same time that the soiling began. Since this time Jessica has soiled regularly, typically around
four to five times a day. Helen said that there had been periods when Jessica had not soiled but Helen felt that during these periods Jessica was avoiding defecation.

Helen reported that she monitored Jessica’s toileting quite carefully and would always inspect the toilet bowl after Jessica had visited the toilet to assess how much defecation had occurred. Helen suggested that her concern over this issue might be contributing to the problem. She had noticed that Jessica seemed to use the toilet more successfully when she was out and Jessica was at home with David. Helen questioned, however, ‘how much’ Jessica produced on these occasions, as David did not monitor this. Helen said she often felt that Jessica was soiling on purpose and that she felt “quite cross” with her. Helen did not believe that Jessica was suffering with Hirschsprung’s disease and suggested that this diagnosis was only being considered because her sister’s child has this condition.

David felt that Jessica was very anxious about going to the toilet and Jessica herself said that she didn’t like toilets. Helen also agreed that often Jessica seemed very worried about going to the toilet and that she would often try to avoid going and try to get off as soon as possible. Helen felt that Jessica was very reluctant to ‘push’ when on the toilet. It was also mentioned that Jessica did not like to use toilets outside of the home and school.

**Family Background**

Jessica is Helen and David’s second child. In total Helen and David have four daughters ranging from one to six years old. Helen has suffered with postnatal depression following the birth of her two youngest children and says that she has struggled constantly since the birth of child number four. She often feels tired and overwhelmed with caring for four young children. She says, however, that she enjoys being a mum despite the workload and feels that she worries too much and should enjoy being with her children more.
Helen reported often feeling stressed and also under attack from her family who she feels are very critical of her. In particular, Helen feels that her mother views her as a failure because of Jessica’s toileting problem and has not told her mother that the family is seeing a psychologist as she feels this would further highlight her shortcomings as a parent. Helen also feels she is being pressured by her sister Jane who strongly suspects that Jessica might have Hirschsprung’s disease, a condition which Jane’s son has been diagnosed with. Helen does not agree with this but feels she has to put Jessica through a biopsy to “shut her [Jane] up”. Helen and David feel quite angry about Helen’s family’s lack of support and criticism. David, however, feels better able than his wife to ignore these perceived criticisms and he thinks that Helen should just ignore her family.

**Toileting Diary**

Helen and David agreed to keep a toileting diary whilst awaiting the biopsy appointment and result. An example page of the diary used is given in Appendix 8. Helen and David provided information on Jessica’s soiling for fourteen days.

On every day recorded Jessica would soil four to five times. On three days she soiled on four occasions with the clean period occurring between 4pm and 8pm. There was no recorded information which correlated with these clean times and the family could not think of any differences about these three times. On all other days Jessica was found to have soiled herself at each recorded time point. Helen’s observation that Jessica used the toilet more when she was out on Saturdays was not reflected in the data and Jessica soiled herself five times on both of the days when Helen was out.

**Initial Formulation**

The information gathered from the assessment stage was summarised using Carr’s (1999) model for considering the influences on problem development in children and adolescents (see Figure 2.). This diagram provided a useful way to organise the predisposing, precipitating, maintaining and protective factors (both personal and contextual) that might be influencing Jessica’s toileting behaviour.

The biopsy revealed that Jessica did not have Hirschsprung disease so this could be discounted as a cause of the difficulty. There remained the possibility, however, that Jessica was predisposed to toileting difficulty through a developmental delay or genetic vulnerability.
The precipitating factor seems to have been an incident on holiday when Jessica had a painful toileting experience possibly because of an anal fissure. Another or additional possibility is that Helen’s toilet training might have been experienced as intrusive. It seems, however, that whatever the initial cause, Jessica’s soiling is being maintained psychologically by an anxiety of defecation and also of generally being in a toilet. In addition, given that Jessica’s toileting difficulty has been continuing for some two years it seemed plausible that she might have poor internal cues alerting her to when she needed to use the toilet and that this might also be maintaining her problem. Related to this is the fact that Jessica has been treated on and off with laxatives and that may have further compounded her ability to monitor her internal cues appropriately.

As well as considering Jessica’s role in the maintenance of the problem there were contextual factors which also seemed to be perpetuating the difficulty. For example, over the last two years Helen and David had tried a number of strategies to help Jessica including star charts, laxatives and punishment strategies. They admitted, however, that no strategy was followed for more than two weeks. This was because they didn’t get any immediate result and then they would start to think that maybe Jessica did have Hirschsprung or that there was some other biological cause or that the problem would just go away by itself. It seems likely that this inconsistency of approach might have caused further anxiety for Jessica and that the repeated failures to solve the problem might have also have resulted in low efficacy beliefs and learned helplessness.

As well as their inconsistency in managing the soiling, there were other aspects of Helen and David’s response to the problem which needed to be considered as maintaining factors. One possibility was that Helen and David were inadvertently reinforcing the problem by rewarding Jessica’s soiling with attention. David works full time in a demanding job and also suffers with back pain. Helen reported often feeling stretched between her four children. In competition for attention with three young siblings, it might be the case that Jessica gets parental attention when she soils but not at other times; from Jessica’s perspective it might seem that she only gets attention around the issue of toileting.
Figure 2. Diagram of influences on Jessica’s toileting difficulty (Carr, 1999)

PREDISPOING FACTORS

Personal predisposing factors
- Biological
  - Genetic vulnerability?
- Psychological
  - Developmental delay?

Contextual predisposing factors
- Family problems in early life
  - Maternal depression

PRECIPITATING FACTORS
- Anal fissure
- Intrusive bowel training?

PERSONAL MAINTAINING FACTORS

Biological factors
- Poor sensation of desire to defecate leading to further constipation and overflow soiling

Psychological factors
- Avoidance of defecation due to fear of anal fissure related pain
- Avoidance of toilets due to fear of being locked in
- Low self-efficacy beliefs and learned helplessness due to inability to resolve

CONTEXTUAL MAINTAINING FACTORS

Treatment system factors
- Inconsistent application of treatment plan by family

Family system factors
- Inadvertent reinforcement of problem behaviour
- Coercive interaction in management of encopresis

Parental factors
- Low maternal self-esteem

Social network factors
- Poor social support network

PERSONAL PROTECTIVE FACTORS

Biological factors
- Good general health (eats well, sleeps well)

Psychological factors
- Good social skills
- Motivated by praise

CONTEXTUAL PROTECTIVE FACTORS

Treatment system factors
- Family accept there is a problem

Family system factors
- Father involvement
- High marital satisfaction

Social network factors
- High SES
- Positive educational placement
Another possible maintaining factor was Helen’s occasional coercive management of Jessica’s toileting. Helen reported that when stressed or tired she would often become frustrated with Jessica and believe that Jessica was soiling on purpose for attention. On these occasions she might shout at Jessica and reprimand her for soiling herself. This management style could be contributing to Jessica’s anxiety and sense of helplessness. In addition, if ‘attention-seeking’ was a factor in this problem, these reprimands would still be providing Jessica with an interaction.

Final considerations for maintaining factors are some parental and social network factors. It was apparent from the initial assessment that Helen had low self-esteem and she often demonstrated a depressive attributional style, blaming herself for the difficulty with Jessica and judging herself a failure for not having been able to solve the difficulty already. In addition, Helen had a poor social support network that consisted of only her mother and sister. Helen often vocalised fears about wasting my time or that she was doing something wrong and she felt that her family, especially her mother, regarded her as a failure. Helen did not socialise with other parents because she said she did not have time but she also confessed that she avoided other parents, as she did not want them to know about Jessica’s difficulty and also think that she was a failure.

Considering the protective factors in this case, Jessica presented as a happy child with good social skills and good general health. Previous investigations by the Health Visitor had revealed that Jessica ate a good diet and that she had a good sleep routine. Jessica was performing well at school and had a good relationship with her teachers. Other positive considerations were that the family was financially well off, that Helen and David both reported high marital satisfaction and mutual support and that both Helen and David accepted that there was a problem and were committed to improving Jessica’s difficulty.

**Intervention**

The intervention used with the family was the Solihull Approach. A Consultant Clinical Psychologist from the CAMHS service recommended the use of this intervention with this case. The Solihull Approach has been specifically devised for professionals working with children and families to address feeding, sleeping, toileting and behavioural difficulties (Douglas, 2004). Although as yet there is no established evidence base for this approach, a pilot evaluation has reported statistically significant favourable results (Milford, Kleve, Lea, & Greenwood, 2006). In addition, professionals have reported good outcomes when using this approach for working with
families (Douglas & Brennan, 2004; Douglas & Ginty, 2001; Whitehead & Douglas, 2005) and over forty NHS trusts and Sure Start units have carried out training in the Solihull Approach across the country.

The theoretical model, which underpins the Solihull Approach, integrates three psychological concepts. These three components are containment, reciprocity and behaviour management. The components are linked and the idea is to progress between them; the experience of emotional containment will support reciprocity which, in turn, will provide a good base for implementing sensitive behaviour management (Douglas, 2004).

Containment is a theory from the psychoanalytical tradition which was developed by Bion (1959). It describes a process whereby a parent is able to help a child process intense emotions and anxiety, rather than the child being overwhelmed by them. Within the Solihull Approach the practitioner aims to contain the anxiety and overwhelming feelings of the parents, restoring in them the ability to think. The Solihull Approach suggests that when the ability to think is restored, parents can sometimes be empowered to solve the problem for themselves.

Reciprocity was first described by Brazelton et al. (1974) and is essentially referring to the attunement between parent and child. In terms of intervention, the level of reciprocity between parent and child can give clues as to the nature of their relationship and highlight areas to be dealt with. A parent and child might be out of sync, for example, because the parent has expectations that would be appropriate for an older child.

The behaviour management part of the model is taken from learning theory (Watson, 1930) and uses strategies taken from operant (Skinner, 1938) and classical conditioning (Pavlov, 1927) to encourage desired behaviours and extinguish unhelpful ones. This component of the Solihull Approach is not introduced until containment and reciprocity between the parent and child are evident.

Although the whole family had attended the initial assessment session, only Helen and her daughters attended the following five sessions. In the first two sessions, containment and reciprocity were the focus of the work. Containment was used to help Helen deal with her anxiety and her overwhelming feelings about not being a ‘good enough’ parent/daughter. We explored Helen’s relationship with her family and thought about the origins of some her negative thoughts about being a failure as a parent.

Helen described her mother as having very high expectations and always being concerned about what others might think of her. She went on to trace her own mother’s difficulties to the fact that her mother had died at a young age from cancer. When Helen made this connection during the session she became very tearful and said that she felt she could begin to understand
some of her mother’s behaviour. During this episode, as Helen became tearful her daughters stopped their play and looked to her. Helen explained to them that, she was thinking about something from her past that made her sad but that she was ok. This sequence suggested that Helen felt ‘contained’; she had been able to make sense of some difficult early experiences and had been able to contain her daughters’ anxieties.

The reciprocity part of the intervention aimed to bring the family more in tune with Jessica’s experience of her difficulty. In the formulation, Helen’s view that Jessica’s difficulty was purposeful behaviour was hypothesised to be a maintaining factor as it led to coercive interactions about toileting and likely added to Jessica’s feelings of anxiety around toileting. To help Helen respond to Jessica’s anxiety more sensitively we spent some time developing an understanding how the difficulty had come about. This involved thinking back over Jessica’s development and toilet training and thinking about the possible precipitating factors. In addition to the painful toileting experience that had been discussed briefly during the assessment, Jessica revealed a second toileting incident that had occurred at school. Jessica said that about a year ago she had had to climb under the toilet door to escape when the lock had stuck. Helen was surprised when Jessica revealed this and responded to sensitively to Jessica saying that now she understood why Jessica didn’t want to go to the toilet alone.

To further help Helen reframe Jessica’s problem, we also considered how the family could create a “facilitative family environment” (Carr, 1999; p217) to maximise the chances for Jessica to learn appropriate toileting behaviour. The aim here was to further improve reciprocity between Helen and Jessica and to encourage reciprocity outside of sessions and with the rest of the family.

According to Carr, a facilitative family environment is one in which the parents send the child the message that the child is respected and loved. Also, the problem is believed to be non-intentional and experienced by the child as uncontrollable. The parents should also convey that they believe the child has great courage for coping with this problem and, that they believe the child can overcome the problem with their support. It was also hoped that this environment would help address low self-efficacy beliefs that Jessica may have developed over several failed interventions.

The behaviour management aspect of the intervention began from week five of the intervention. Helen and David had spoken in the assessment about how, in the past, strategies had not been followed up for any length of time because they were often difficult to find time for in their busy household. The behavioural management plan, therefore, was devised in close
collaboration with Helen (who discussed ideas outside of sessions with David) so that she felt the plan could be carried out consistently.

Based on Helen’s observations of strategies that had had some success in the past and a consideration of all the factors that might be contributing to Jessica’s problem, a number of changes were instigated. This included a classical conditioning strategy with a new routine around toileting being developed. This meant that toilet visits were now scheduled around mealtimes with visits occurring thirty minutes after a meal. This meant a new morning routine so that Jessica had breakfast before getting dressed to allow a scheduled toilet break managed by David to occur just before leaving for school.

Operant conditioning was also used to reward Jessica for appropriate toileting behaviour. A smiley chart was used so that, for example, one face could be coloured in for visiting the toilet and three for managing to pass stools. Helen also wanted to use the smiley chart to encourage Jessica to drink more fluid and so a face was also coloured in if Jessica had a drink. When sheet with 25 faces on it had been coloured in Jessica was taken swimming after school. Swimming was a desirable outcome for Jessica and an activity which Helen and David felt they would like to be encouraging more.

Other behaviour management strategies suggested by the formulation were for Helen and David decided to make sure that Jessica received attention for other activities (i.e. Jessica not just given attention for issues related to toileting) and they also tried to minimise attention when Jessica had soiled herself.

Results of Intervention

The intervention was monitored using a toileting diary (Appendix 8). The family completed a toileting diary for four weeks prior to the intervention plan being implemented that provided baseline data for Jessica’s soiling. In week 5 the family put the intervention plan into practice at home (e.g. began using smiley charts and scheduled toilet breaks) and they completed the diary for another three weeks. The results are illustrated in Figure 3 which shows the number of dry and clean periods that Jessica had during each week that data was collected (see Appendix 9 for a summary of the results for each day).

Visual inspection of the data shows that no improvement in number of dry periods was observed from the baseline to the intervention phase. In addition Helen did not feel that there had been any change in Jessica’s toileting and examination of the toileting diary pages did not
indicate any pattern to the dry periods in either phase (see Appendix 9 for a summary of the results for each day).

Figure 3. Number of clean and dry periods across weeks

Discussion and Reflections

Over the course of the baseline and intervention periods there was no change in Jessica’s toileting difficulty. This was extremely frustrating both for Helen and myself (and probably for Jessica too). In the earlier stages of the work I had been optimistic that a change in Jessica’s toileting would be achieved in the time we had available; the family were engaged, motivated and well educated. It seemed to me that the family would have sorted this difficulty out already if they hadn’t had a possible diagnosis of Hirschsprung’s ‘hanging over’ them, so when the biopsy result came back as negative, I thought the family would be ready and able to address this issue.

During the intervention period Helen and I met weekly to discuss progress. Each week a similar story unfolded, so that the intervention plan would be followed for a few days but then
Helen would not feel that it was working, or the family would be too busy and chaotic and the plan would be forgotten. Helen would acknowledge the fact that any intervention plan needed to be followed consistently and that any plan would take time to work. Helen, therefore, felt that not following the plan was evidence that she was a poor parent.

In terms of the intervention plan it seemed that the ‘containment’ part of the approach was not having the intended outcome. The aim of the containment was to help Helen to contain her anxieties and restore her ability to think clearly about the problem. Helen and I spent one session exploring her family history and relating this to her thinking style. Although Helen reported the session as being useful it did not seem to change her thinking style. I suggested to Helen that it might be useful for us to spend some sessions exploring her thoughts and using a cognitive behavioural approach to tackle some of her dysfunctional beliefs (e.g., I’m a failure as a parent). Unfortunately, however, Helen was not keen to try this and felt that she should solve Jessica’s problem before dealing with her own issues. The original intervention plan was, therefore, continued.

I also suggested that Helen might benefit from attending a locally run parenting group. Helen has a poor social network and little support and I felt that such a group might also be able to perform some containment for Helen and that seeing other parents with child difficulties might challenge her perception of herself as a failure. Helen, however, also refused this suggestion and said she wished to persevere with the behavioural management strategies we had begun.

On reflection I feel now that I progressed too quickly from containment and reciprocity to the behavioural management aspect of the Solihull Approach. I think that my lack of experience, the time constraints of the placement and Helen’s reluctance to explore her own issues, encouraged me to progress to the behavioural management aspect of the intervention before the family were ready. I think that, like Helen, I too felt more comfortable with the behavioural management part of the planned intervention and perhaps we colluded to move on past the more difficult and complex issues at hand. With hindsight I would have spent further sessions developing the containment and reciprocity components of the intervention. Although this would have been difficult with the time available, it was in the end counterproductive to try and move forward before the time was right.

This case highlights a number of issues which I also encountered in other cases whilst on my CAMHS placement. Although I was aware of some of these issues before I began this placement I think now that I had underestimated how difficult these issues would be to negotiate. First, is the issue as to who is the client. Even though Helen could acknowledge how her beliefs might be contributing to her failure to follow the intervention plan she was not prepared to
consider an intervention which might address these. There are several other parents from families on my caseload who have also shown reluctance to engage in any work which might be related to them, instead the work is steered towards focussing on the child. I wonder if as a trainee I have not been direct enough with some parents as to where the needs lie, however, I also feel that if I had been more direct, particularly with Helen, that she may have disengaged and stopped attending sessions altogether.

A second issue relates to parental support and this also cropped up in several clients from my caseload. With these clients the mother of the family is struggling to cope with several young children and in need of more support to be able to engage in an intervention. With four young children to care for, Helen was in great need of support but had none other than David who had a very demanding job. Although I have long been aware of how important social support is in the literature in terms of people’s outcome and I had listed it in this case as a maintaining factor, I think I had underestimated in my mind how much of a barrier to progress this can be.

A final point to be considered here is the fact that the aim of this piece of work was to carry out a single case experiment. This was not a very satisfactory experiment, as the data showed no change from the baseline to the intervention phase. The data, however, does clearly show that the intervention did not work in the time available and that an alternative approach should be investigated. With other clients on this placement I have had parents telling me that things are improving but then their accounts of daily life do not seem to suggest that this is the case, at least here the data is unequivocal.
References


CPR 5: Clinical Presentation

An older adult referred for fetishistic transvestism and depression
Abstract

A case study of a male older adult referred to psychology for “initial assessment and psychotherapy if necessary” is presented. The referring psychiatrist described the client as depressed and displaying fetishistic transvestism. The assessment and formulation for this case are discussed.

Through the course of clinical interview the client presented with difficulties which prompted an assessment of his neuropsychological functioning. The results of these investigations in some ways seemed to offer a good explanation for the behaviours exhibited by the client. There were, however, other aspects of his presentation that did not match with the neuropsychological evidence. A further understanding of this client was, therefore, sought and a psychodynamic formulation was developed and is also presented.

Although very different perspectives, the neuropsychological and the psychodynamic approaches contributed to building an understanding of this client and recommending appropriate courses of action which would not have been indicated from one approach alone.
Appendices
Appendix 1

Service Evaluation Patient information sheet
PATIENT INFORMATION SHEET

What is the Quality of Life study about?
The aim of this evaluation is to give us a better understanding of how you feel about life at XXXX. We believe that this will help us to improve the quality of life of patients receiving treatment here.

What will I have to do?
If you agree to participate you will be asked to work through four questionnaires. Altogether this should take less than one hour to complete.

What are the risks?
Sometimes people may find some questions difficult or too personal to answer. If you feel like this you do not have to answer those questions. If you feel low in mood whilst completing the questionnaire you can speak to your key or co-worker or to members of the psychology department that are involved in the evaluation.

What if I do not want to take part?
You just have to say that you would not like to. If you do not wish to take part this will not affect your current or future treatment in any way.

What happens to the information?
A brief summary will be produced for your clinical team unless you object to this. If you identify any problem areas in your life at XXXX and wish your clinical team to be contacted to try to improve your quality of life this can be requested. All responses will be kept in a locked filing cabinet. For the purpose of the evaluation, all of your responses will remain anonymous and completely confidential.

Who else is taking part?
All patients at XXXX will be asked if they would like to take part.

What happens at the end of the evaluation?
A report will be produced summarising the quality of life of all patients in the clinic and will suggest what changes need to be made to improve this.

What if I have more questions or do not understand something?
If you have any further questions or do not understand something, please ask your key or co-worker who will help you. If you have any other questions you can contact the co-ordinator directly (her name and contact details are at the end of this leaflet).

What happens if I change my mind whilst completing the questionnaire?
If you change your mind, simply inform the interviewer that you wish to withdraw. Any information you have provided will then be excluded from the research.

Contact name and number
If you have any problems in connection with this study or have further questions please contact: XXXXXXX or XXXXX, Trainee Clinical Psychologists
Appendix 2

Service Evaluation Patient consent form
CONSENT FORM

I, __________________________ agree to answer some questions about my life at XXXX. The reasons for this quality of life evaluation have been explained to me by ______________________. I have been given a copy of the information sheet to keep. I have been told that I do not have to take part and that I may stop at any time. I have also been told that it will make no difference to my care and treatment, now or in the future, if I do answer the questions or choose not to.

Name (Printed): __________________________
Signed: __________________________
Date: __________________________

Witness Name (Printed): __________________________
Witness Signature: __________________________
Date: __________________________
Appendix 3

Lancashire Quality of Life Profile and Life Satisfaction Scale
1. Introduction

- Go through information sheet with patient
- Explain that the procedure will take about 30 minutes
- Encourage patients to be open and honest. Reassure that all responses are anonymous
- Ask patient to sign consent form

2. Give the patient the Life Satisfaction Scale (LSS)

“Please look at this. This is a chart which will help you to describe how you feel. We will be using it throughout the interview to help you with questions about many areas of your life. All you have to do is to point to the part of the chart which best describes how you feel when you are asked. As you can see, it covers all of the feelings from when you are most satisfied to when you are least satisfied.

“For example, if I asked you if you liked fish and chips you might say ‘couldn’t be better’ if you really liked them a lot. This would show the strongest possible satisfaction or approval. On the other hand, if you hated fish and chips you might point to ‘couldn’t be worse’. This would show the strongest dissatisfaction. If you felt about equally satisfied and dissatisfied with fish and chips you would point to the middle of the chart and ‘mixed’. This would tell me that you were uncertain or had mixed feelings. As you can see there is room for many shades of opinion in either direction.”
3. Interview
(Please write the number indicated on the LSS in the box)

1. Can you tell me how you feel about your life as a whole today

2. How satisfied are you with:
   a. Your occupational therapy?
   b. The amount of money that you make?
   c. Being unemployed or retired?
   d. The amount of pleasure from this you do at home?
   e. The amount of pleasure from this you do outside your home?
   f. The pleasure you get from radio or tv?
   g. Your religious faith and its teaching?
   h. The frequency with which you attend services?
   i. How well off you are financially?
   j. The amount of money you have to spend on enjoyment?
   k. The living arrangements here?
   l. The amount of independence you have here?
   m. The amount of influence you have here?
   n. Living with the people who you do?
   o. The amount of privacy you have here?
   p. The prospect of living here for a long time?
   q. Your general personal safety
   r. The safety of this neighbourhood?
   s. Your family in general?
   t. The amount of contact you have with your relatives?
u  Your marriage? (If applicable)                      

v  The way that you get on with other people?        

w  The number of friends you have?                   

x  Your general state of health?                    

y  How often you see a doctor?                      

3.  Can you tell me how you feel about your life as a whole? 


Life Satisfaction Scale:

1  2  3  4  5  6  7

Couldn’t be worse  Displeased  Mostly dissatisfied  Mixed  Mostly satisfied  Pleased  Couldn’t be better
Appendix 4

World Health Organisation Quality of Life Assessment
WHOQOL-BREF

The following questions ask how you feel about your quality of life, health, or other areas of your life. I will read out each question to you, along with the response options. **Please choose the answer that appears most appropriate.** If you are unsure about which response to give to a question, the first response you think of is often the best one. Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in the last four weeks.

<table>
<thead>
<tr>
<th></th>
<th>Very poor</th>
<th>Poor</th>
<th>Neither poor nor good</th>
<th>Good</th>
<th>Very good</th>
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</thead>
<tbody>
<tr>
<td>1. How would you rate your quality of life?</td>
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<tr>
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<th>Very dissatisfied</th>
<th>Dissatisfied</th>
<th>Neither satisfied nor dissatisfied</th>
<th>Satisfied</th>
<th>Very satisfied</th>
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<tr>
<td>2. How satisfied are you with your health?</td>
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The following questions ask about **how much** you have experienced certain things in the last four weeks.

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<th>Not at all</th>
<th>A little</th>
<th>A moderate amount</th>
<th>Very much</th>
<th>An extreme amount</th>
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<td>3. To what extent do you feel that physical pain prevents you from doing what you need to do?</td>
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<td>4. How much do you need any medical treatment to function in your daily life?</td>
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<td>5. How much do you enjoy life?</td>
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<td>6. To what extent do you feel your life to be meaningful?</td>
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</table>
7. How well are you able to concentrate?  

8. How safe do you feel in your daily life?  

9. How healthy is your physical environment?  

The following questions ask about how completely you experience or were able to do certain things in the last four weeks.  

10. Do you have enough energy for everyday life?  

11. Are you able to accept your bodily appearance?  

12. Have you enough money to meet your needs?  

13. How available to you is the information that you need in your day-to-day life?  

14. To what extent do you have the opportunity for leisure activities?  

15. How well are you able to get around?  

16. How satisfied are you with your sleep?  

17. How satisfied are you with your ability to perform your daily living activities?  

18. How satisfied are you with your capacity for work?
19. How satisfied are you with yourself?

20. How satisfied are you with your personal relationships?

21. How satisfied are you with your sex life?

22. How satisfied are you with the support you get from your friends?

23. How satisfied are you with the conditions of your living place?

24. How satisfied are you with your access to health services?

25. How satisfied are you with your transport?

The following question refers to how often you have felt or experienced certain things in the last four weeks.

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<th>Never</th>
<th>Seldom</th>
<th>Quite often</th>
<th>Very often</th>
<th>Always</th>
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<tbody>
<tr>
<td>26. How often do you have negative feelings such as blue mood, despair, anxiety, depression?</td>
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Appendix 5

Therapeutic Relationships Questionnaire
Therapeutic Relationship Questionnaire (TRQ)

The following questions ask you to rate the care you are receiving here at XXXX clinic.

We are interested in your view of the treatment you receive from your psychiatrist, your psychologist, your occupational therapist and your key worker.

Your answers are confidential.

For each question use the rating scale and place a mark according to your rating.

EXAMPLE:

Not at all  ×  Yes entirely

Please answer the questions below thinking about the treatment you receive from your psychiatrist.

1. Do you believe you are receiving the right treatment for you from your psychiatrist?

Not at all  ×  Yes entirely

2. Does your psychiatrist understand you and is s/he engaged in your treatment?

Not at all  ×  Yes entirely

3. Do you feel respected and well regarded by your psychiatrist?

Not at all  ×  Yes entirely
Please answer the questions below thinking about the treatment you receive from your **psychologist**.

1. Do you believe you are receiving the right treatment for you from your **psychologist**?

   | Not at all | | | | | | | | | | | Yes entirely |

2. Does your **psychologist** understand you and is s/he engaged in your treatment?

   | Not at all | | | | | | | | | | | Yes entirely |

3. Do you feel respected and well regarded by your **psychologist**?

   | Not at all | | | | | | | | | | | Yes entirely |

Please answer the questions below thinking about the treatment you receive from your **occupational therapist**.

1. Do you believe you are receiving the right treatment for you from your **occupational therapist**?

   | Not at all | | | | | | | | | | | Yes entirely |

2. Does your **occupational therapist** understand you and is s/he engaged in your treatment?

   | Not at all | | | | | | | | | | | Yes entirely |

3. Do you feel respected and well regarded by your **occupational therapist**?

   | Not at all | | | | | | | | | | | Yes entirely |
Please answer the questions below thinking about the treatment you receive from your **key worker**.

1. Do you believe you are receiving the right treatment for you from your **key worker**?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Yes entirely</th>
</tr>
</thead>
</table>

2. Does your **key worker** understand you and is s/he engaged in your treatment?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Yes entirely</th>
</tr>
</thead>
</table>

3. Do you feel respected and well regarded by your **key worker**?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Yes entirely</th>
</tr>
</thead>
</table>
Appendix 6

Observation recording sheet
Observation recording sheet

Date _____________________

<table>
<thead>
<tr>
<th>Time</th>
<th>Location</th>
<th>Task</th>
<th>Teacher input</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1  2  3  4 Group Alone 1  2  3  4</td>
<td>Work</td>
<td>Toilet</td>
</tr>
<tr>
<td></td>
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<td>1  2  3  4</td>
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</table>

Location 1=classroom, 2=corridor, 3=outside, 4=other  
Teacher input: 1=one-to-one, 2=no individual input, 3=praising, 4=reprimanding
Appendix 7

Motivation Assessment Scale
Instructions: The Motivation Assessment Scale (MAS) is a questionnaire designed to identify those situations in which an individual is likely to behave in certain ways. From this information more informed decisions can be made concerning the selection of appropriate reinforcers and treatments. To complete the MAS, select one behaviour that is of particular interest. It is important that you identify this behaviour very specifically. Aggressive for example is not as good a description as hits his sister. Once you have specified the behaviour to be rated, read each question carefully and circle the one number that best describes your observation of this behaviour.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Never</th>
<th>Almost Never</th>
<th>Seldom</th>
<th>Half the Time</th>
<th>Usually</th>
<th>Almost Always</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Would the behaviour occur continuously, over and over, if this person was left alone for long periods of time? (For example, several hours).</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
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<tr>
<td>2. Does the behaviour occur following a request to perform a difficult task?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
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<tr>
<td>3. Does the behaviour seem to occur in response to your talking to other persons in the room?</td>
<td>0</td>
<td>1</td>
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<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>4. Does the behaviour ever occur to get a toy, food, or activity that this person has been told that he or she can’t have?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>6</td>
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<tr>
<td>5. Would the behaviour occur repeatedly, in the same way, for very long periods of time, if no one was around? For example, rocking back and forth for over an hour).</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<td>4</td>
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<td>6. Does the behaviour occur when any request is made of this person?</td>
<td>0</td>
<td>1</td>
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<td>7. Does the behaviour occur whenever you stop attending to the person?</td>
<td>0</td>
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<tr>
<td>8. Does the behaviour occur when you take away a favourite toy, food or activity?</td>
<td>0</td>
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<td>9. Does it appear to you that this person enjoys performing the behaviour?</td>
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<tr>
<td>10. Does this person seem to do the behaviour to upset or annoy you when you are trying to get him or her to do what you ask?</td>
<td>0</td>
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<tr>
<td>11. Does this person seem to do the behaviour to upset or annoy you when you are not paying attention to him or her? (For example, if you are sitting in another room or interacting with another person).</td>
<td>0</td>
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<td>5</td>
<td>6</td>
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Appendix 8

Toileting Diary
<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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</thead>
<tbody>
<tr>
<td><strong>Dry and clean at 8am</strong></td>
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<tr>
<td></td>
<td>Comment on size of accident, what was happening before and after.</td>
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<td><strong>Dry and clean at 12 noon</strong></td>
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<td>Comment on size of accident, what was happening before and after.</td>
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<td><strong>Dry and clean at 4pm</strong></td>
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<td>Comment on size of accident, what was happening before and after.</td>
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<tr>
<td><strong>Dry and clean at 8pm</strong></td>
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<td>Comment on size of accident, what was happening before and after.</td>
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<tr>
<td><strong>Dry and clean at 12 midnight</strong></td>
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<td>Comment on size of accident, what was happening before and after.</td>
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Appendix 9

Summary of toileting diary
<table>
<thead>
<tr>
<th>Week</th>
<th>Day</th>
<th>8am</th>
<th>12 noon</th>
<th>4pm</th>
<th>8pm</th>
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Appendix 10

Modifications to clinical presentation
For the initial neuropsychological assessment of Peter the CAMCOG(R) was administered. Within the service to which Peter had been admitted the CAMCOG(R) is the standard assessment instrument which all members of the multi-disciplinary team can administer and score. This instrument is used routinely whenever there is a question about cognitive functioning or to establish a baseline for future assessments. The CAMCOG(R) has been reported to be a valid screening instrument for differentiating between demented and non-demented subjects (Heinik & Solomesh, 2007).

The results of Peter’s CAMCOG(R) were in the range which suggested possible dementia. It was decided to try and investigate further if Peter might be having difficulties with his executive functioning. The CAMCOG(R) identified this as an area of weakness and there were behavioural aspects of Peter’s presentation which could be interpreted as indicators of dysexecutive syndrome.

To test for dysexecutive syndrome the BADS (Behavioural Assessment of Dysexecutive Syndrome), the D-KEFS (Delis-Kaplan Executive Function System), and the Hayling and Brixton tests were considered. Peter was reluctant to undertake more neuropsychological testing; the CAMCOG(R) was difficult and time consuming for him. It was decided, therefore, to ask Peter if he would agree to a short test (the Hayling and Brixton tests) which would take approximately fifteen minutes. (The BADS and the D-KEFS are much lengthier instruments, which take at least fifty minutes to complete). Peter agreed to this plan and completed the Hayling Brixton tests on which he scored in the impaired range on all sections, consistent with a dysexecutive syndrome diagnosis.

The results of Peter’s neuropsychological assessments indicated that further investigation of his cognitive functioning was warranted and, therefore, a CT scan and an Occupational Therapy (OT) assessment were recommended. These further assessments were needed to clarify if a diagnosis of dementia was appropriate and whether there might be specific deficits with Peter’s executive functioning. Although the CAMCOG(R) and Hayling Brixton results would suggest that this was the case, Peter’s independent living arrangements and his presentation in the Day Hospital were not consistent with the extremely impaired presentation that would be predicted by these results. The scan and OT assessment were suggested as the next stage of intervention because further neuropsychological assessment may not have been consented to and this was not the preferred option for the client. In addition, any further neuropsychological assessments would also likely need clarification from an OT assessment and CT scan to confirm a diagnosis.

In trying to formulate Peter’s difficulties, a purely neuropsychological approach seemed inadequate and was unable to account fully for Peter’s presentation. The rationale for
pursuing a psychodynamic understanding of his case can be summarised in the following points:

- Peter’s childhood history of abandonment and separations seemed likely to be relevant to his reported feelings of loneliness and depression. Psychodynamic approaches acknowledge the importance of early experience in the development of psychological distress and are well suited to working with material derived from feelings of abandonment and isolation (Hepple, 2004).

- Psychodynamic approaches make use of the phenomenon of transference and countertransference which can help the therapist to understand the state of mind of the client (Hinshelwood, 1991). Using the transference and countertransference to develop an understanding of Peter was particularly useful because it offered a means of making sense of his pain and distress despite his reluctance to communicate these directly.

- As with any psychological intervention, good supervision is necessary for effective practice. In psychodynamic work with older adults, good supervision is essential for making sense of the powerful feelings that can be evoked by working with this client group (Garner, 2002). The decision to pursue this approach, therefore, was also made in light of the knowledge that access to psychodynamic supervision was available.

- There is some evidence to suggest that for older clients, psychodynamic work can be as effective as CBT in dealing with depression (Thompson et al., 1987). In addition, Bob Knight (e.g., 1986 1996) has written several papers and books which support the use of this approach in older adult work.

Although a psychodynamic approach was pursued to understand and formulate Peter’s case, a psychodynamic intervention was not pursued. This was because Peter did not wish to undertake any further psychology sessions. Had Peter wished to pursue a psychological intervention, it would have been important to wait for the outcome of his CT scan and OT assessment. If these assessments supported a diagnosis of dementia and/or dysexecutive syndrome, it would be necessary to reformulate and reconsider Peter’s case in light of this before embarking on an intervention.
References


